

# Immigration Pediatrics

*An inner-city pediatrician finds himself in a medical no-man's land where social policies undermine the care of his newly arrived immigrant patients—and their contributions to society.*

BY FITZHUGH MULLAN

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*PREFACE: Travel makes us all foreigners of one sort or another. Travel can be a desperate act, as in the case of Central American economic immigrants coming to the United States, or it can be a volitional one, as in the case of an economist on a study fellowship. In both instances, being foreign creates new obstacles and new perspectives. Fitzhugh Mullan, a pediatrician working in inner-city Washington, D.C., is the first point of contact with the medical system for numbers of immigrant children. The many obstacles and the new perspectives that he and his patients encounter are what he calls "immigration pediatrics." Rhiannon Edwards, a blind health economist from Wales, spent a year in the United States studying health care. During the visit, both she and her guide dog needed clinical attention, back-to-back experiences that provided her with new perspectives on how Americans feel about choice in their lives. As a foreigner who came to the United States with different health care and coverage experiences, she shares her views on what the American penchant for choice really costs and in what ways it produces gains and losses.*

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I WAS PERPLEXED. The young woman accompanying the four-year-old to my office for an anemia re-check seemed vague about the child's health and couldn't tell me if he had finished the prescribed course of medication. I suddenly understood. "You're not his mother." "No, I'm not," she told me. "His mother is at work. I'm his sister." She was seventeen years old and understandably uncertain about the child's health, as she had arrived from El Salvador only ten days before. She spoke no English, was undocumented, and had not enrolled in school; she was just getting to know her mother, whom she hadn't seen in five years, and her young brother, whom she hadn't met before. I examined the child, reordered a blood test, and gave the sister an appointment for an exam—for herself, something she would need before she could go to school.

I practice pediatrics at a community health center in inner-city Washington, D.C., and the reality of immigration is with me every day. A full 90 percent of the children I see are immigrants or the children of immigrants. The majority of them come from Central America or the Caribbean, but Vietnamese, Chinese, and East and West Africans are frequent visitors as well. Although my business card says "pediatrics," in reality I practice immigration medicine.

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In college I took a course in U.S. social history. “We are an immigrant nation,” our professor told us frequently. “The history of the immigrant is the history of America.” I was not convinced. The time was 1963, and immigration history seemed interesting but dated. I had an Irish immigrant grandfather, but, to me, immigration was mostly stories from the past—stories of families left behind, the ocean voyage in steerage, Ellis Island, Chinese workers building the Transcontinental Railway, and slave ships making the deadly passage from Africa. This was American history, all right, but it was not America as I saw it in the 1960s. I was short-sighted.

### New Arrivals And New Citizens

CURRENTLY AN ESTIMATED 1.5 MILLION legal and illegal immigrants arrive in the United States each year. Some 43 percent of immigrant children live in low-income families, and almost one-third do not have health insurance. Each year 750,000 children are born to immigrant women. One way or another, insured or uninsured, sick or well, many of these children pass under the examining hands of pediatricians in a variety of settings, including community health centers such as the one in which I work. Like teachers and social workers, pediatricians constitute an important reception committee for immigrant children in the United States. We are not Hull House or the Henry Street Settlement—well known to earlier immigrants—but we are the conduit to U.S. social services and the first step on the road to becoming Americans. However, like teachers and social workers, we often staff a system that wasn’t designed with the best interests of our patients in mind.

Most of the kids I see are the children of Latino immigrants; they were born in the United States and are U.S. citizens. The neighborhood may be dangerous and the schools lousy, but these children are advantaged compared to their immigrant parents and to children arriving here as immigrants. Kids born here grow up speaking English, are entitled to Medicaid, and enter Head Start and the school system with a leg up. I often see families where the five-year-old responds in English and translates for his non-English-speaking parents.

Many Latino immigrant children have a tougher road. War and poverty have driven their parents from Central America to undertake the perilous, illegal journey to the United States. These people are often among the most industrious and ambitious in the communities from which they come, men and women intent on finding jobs, saving money, and building families. They staff our restaurants, clean our houses and offices, and labor on our construction sites. Adults usually attempt the trip to the United States alone in the hopes of establishing a safe haven to which they can later bring their children. And they do.

The problem is that to save their families, they pull them apart—at least for a time. The children left behind may get the benefit of money, gifts, and clothes sent

home, but they are temporary orphans. Many of the parents in the U.S. remain “illegal,” and when they decide to reunite their families, they have to pay \$7,000–\$10,000 to cover the costs for human smugglers (“coyotes”), bribes, car, bus, and airfare to get a child to Washington, D.C. Parents with no wherewithal to manage intervening events initiate the trip in the hopes that their child will arrive safely in the United States. It is hard to know what percentage succeed in making the trip, since we only see the winners, but many surely fail along the way. Win or lose, these trips are dangerous and expensive.

When these children arrive, they are not eligible for Medicaid or most public assistance. They come to offices like mine for the medical examination and immunizations required to enter school. It is hard to fathom the reunions I regularly see—children raised by a grandmother for ten years suddenly back in the care of their mother. Ten-year-olds entrusted to a stranger to convey them 2,000 miles across three countries for an illegal and uncertain rendezvous with their parents. Teenagers crossing the Sonoran Desert on foot in the hope of finding a ride on an Arizona road that will take them to a bus terminal. There is always a celebratory element to the office visit: “He made it! Wonderful. Congratulations!” But powerfully complex emotions are also going on in the hearts and heads of the children in these reunited families. “Why was I left? How am I going to fit in? Who are these people anyway?”

Newly arrived immigrant children, whether legal or illegal, face the daunting gauntlet of a new school in a new language. Most local schools offer English for speakers of other languages (ESOL) for the newly arrived. While this may work for younger students, youths arriving in high school rarely master English with much proficiency, undoubtedly finding it easier to hang with kids who speak Spanish. Parents are working. City life is fast and rough. The cultural gap can be huge, especially for children from rural communities. I recently cared for a newly arrived seventeen-year-old girl from the countryside of Honduras who had no idea what a condom was or how it was used. The D.C. high school in which she was enrolling has a large infant care center—for the children of students.

### More Than A Medical Mission

**I** DO THE STANDARD THINGS: looking for undiagnosed problems, testing for parasites, applying TB tests, giving catch-up immunizations, and seeking any signs of abuse or neglect. But my medical mission today is different from what it would have been in earlier times, when malnutrition was the leading problem for immigrant children and blindness-causing trachoma and “imbecility” were considered hazards to the nation. Today the risks for arriving youth are less what they bring with them than what happens after they get here.

Several years ago I examined a fifteen-year-old boy newly arrived from El Salvador who came to the clinic accompanied by his mother. He was nicely dressed,

clean-cut—and sullen. The mother looked at me and at the ceiling, but never at him. Six weeks in the U.S, and their ten-year-long dream had come unraveled. Talking with them separately, he told me he couldn't believe she had left him at age five, and she told me he was insolent and didn't appreciate what it had taken to get him here. He had started leaving home in the evening and not returning until the next day. The hostility and disappointment in the room was palpable. Was I watching the end of family life and the start of gang life for this young man? Gangs are large and growing in Washington as in other U.S. cities, providing “community” of a sort for many troubled adolescents and recently arrived youths. Kids like my patient can get recruited quickly and lethally. I talked with him alone about gangs, school, drugs, and violence. He admitted to hanging with gang kids and said that he understood the dangers. He told his mom in my presence that he would try to go to school and come home at night.

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**“As a country, we are schizophrenic about immigrants, welcoming and xenophobic all at once.”**

..... I have many patients whose lives have gone badly at junctures like this—fifteen-year-olds brought in for truancy, pregnant fourteen-year-olds, a twelve-year-old hit in the abdomen by a stray bullet from a gang shootout. Medical care puts a floor under these kids' feet, but life on the street and opportunities in school will be key to their futures. The importance of a pediatrician in the life of this young man was my ability to refer him—much as I might have done if he had a heart murmur. The “prescription” I used was the Latin American Youth Center (LAYC), a nearby street-smart, multipurpose, safe haven for teens. The nonprofit LAYC beats gangs at their own game by providing a place to belong, social life, and an identity, as well as educational opportunities and jobs. It is the LAYC and organizations like it that stand the best chance of protecting my patients from gangs, early pregnancy, drugs, AIDS, and jail.

### Medical No-Man's Land

SUCH ORGANIZATIONS ARE FEW AND FAR BETWEEN, and gangs are ubiquitous and growing. The robust U.S. economy and the ambitions of poor people from around the world are going to keep the arteries of immigration—legal and illegal—flowing briskly for the foreseeable future. Illegal migration in particular creates special hardships for children, of which broken lives, criminality, and disease are too often the outcome. But as a country, we are schizophrenic about immigrants, welcoming and xenophobic all at once. We want their energy and their hustle but not their illnesses or their family problems. We consume their labor in huge quantities, but we're not ready to give them jobs with benefits—or have the government make up the difference. Federal welfare and immigration legislation of the mid-1990s imposed a five-year ban on Medicaid eligibility for all

nonrefugee immigrants; as a result, new programs such as the State Children's Health Insurance Program (SCHIP) don't reach many of my patients. Jobs without insurance and restrictions in public programs mean that 74 percent less is spent on health care for immigrant children than for kids born in the U.S. We want the cheap, flexible, eager muscle of immigrants but not their premature infants, gunshot wounds, or troubled teenagers. As a pediatrician, I often feel as if I labor in a no-man's land between the full-throttle economy and penny-ante social policies.

Fairness, at the least, calls out for change. Reforming immigration laws to give more workers legal status is the place to begin, something the Bush administration has raised as an issue. This would mean that workers could come and go from the U.S. without the fear of arrest and deportation, reducing the pressures that drive families apart and decreasing the number of children raised without parents. This is essential to making immigrant life less intrinsically unfriendly to families. But increased medical and social investments in the immigrant community also are essential, both for fairness and to build better citizens for the future. It is well-funded Medicaid and community health center programs, as well as more youth centers and high-quality schools—all at risk in our current public budgets—that will give these new Americans a better chance at success and make our cities safer as well. The U.S. Supreme Court ruled in 1982 that school systems could not deny undocumented children admission, doing so on the grounds that countenancing children growing up illiterate in America was neither ethical nor in the country's best interests. The same principle needs to be adopted—with the same rationale—for the health care of children. Good access for kids to immunizations, controlling infectious diseases, preventing obesity, providing mental health care, and the like will benefit both the immigrant family and the U.S. workforce of the future. Fully funding Medicaid, ending immigrant-specific restrictions on SCHIP eligibility, providing interpreter services where needed, and requiring employer-sponsored insurance coverage for immigrant workers would be the next steps in building a floor under the health of immigrants.

Recently, the sullen fifteen-year-old boy—now nineteen and smiling—came to visit the clinic to show me, amazingly enough, his high school diploma. He had managed to stay off the streets and master his studies well enough to earn a passing grade, a year or so behind schedule. In English that was accented but clear, he explained his plans to work in construction during the day and take some college classes at night. His mother came with him. She was delightfully proud. She told me that she never thought this would happen. Never. I certainly would not have predicted a positive outcome from the unpromising start in the examination room interview several years before. I was pleased for them and happy to have been a small participant in this tiny piece of American history—the boy becoming a man, the Salvadoran becoming an American, medicine as social service, immigration pediatrics.