

WELCOME TO THE IMMIGRANT HEALTH ISSUE

I am delighted to introduce this important theme issue, which has been evolving over the last 12 months under the insightful leadership of Chris Wong of the University of Washington. Chris has thoughtfully directed a host of authors and associate editors in developing a range of content that should appeal to all SGIM members. Please also note that supplemental content will be posted online, including a wonderful interview with Alice Chen. Sit back and enjoy, and be sure to tell us what you think

—Karen R. Horowitz, Forum Editor

EDITORIAL

Immigrant Health in the Spotlight

Christopher Wong, MD

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CONTENTS

1. Editorial	1
2. New Perspectives	2
3. Essay	3
4. Sign of the Times	4
5. Morning Report	5
6. Commentary	6
7. From the Society	7

Welcome to this month's issue of *Forum*. In this issue we focus on the health of immigrants.

You don't have to look far to find prominent mythologies of immigration in pop culture and the media. There are seemingly positive portrayals of the hard-working immigrant who left everything behind and started a small business—fully assimilating, perhaps bringing a bit of cuisine from the homeland—as well as negative portrayals of the “illegal” immigrant as criminal or lazy or the thick-accented convenience store owner who never quite fits in.

Race and ethnicity are intertwined in the perception of immigrants. Be wary of the pervasive mantra that socioeconomic status trumps everything. One's self-identified race and nationality may be but a gentle breeze against the gale of others' perceptions. You may be a fourth-generation Japanese American but assumed to be a recent immigrant because of your appearance. Wearing a turban or a hijab will inevitably lead to assumptions about you and your immigration history or status. This goes the other way too—you may be a recent immigrant from Europe but assumed to be a non-immigrant based on the perceived cultural norms of your appearance.

The true history of immigration in America is quite complex when deconstructed from the school-taught metaphor of the “melting pot,” the immigrant stereotype mythologies, and our country's difficult relationship with race and ethnicity. Although the European colonial era started the displacement of indigenous populations, it may surprise you to learn that there were no restrictions on immigration at all for much of US history.¹ Free immigration and the blight of slavery marked those

continued on page 8

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Caring for Refugee Patients: An Exceptional
Education

Genji Terasaki, MD, and Aniyizhai Annamalai, MD

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According to the United Nations High Commissioner for Refugees (UNHRC), as of December 2014, more than 19 million refugees were currently living outside of their home countries and unable to return due to violence, torture, or fear of persecution. The conflicts in Syria, South Sudan, and Central Africa have accelerated this trend to rates not seen since World War II.¹

Refugees may spend many years in a refugee camp in a neighboring country while awaiting peace and acceptance in their homeland.

In 2014, the United States accepted approximately 70,000 refugees for permanent resettlement, with the largest numbers originating from Iraq, Bhutan, Burma, Somalia, Congo, and Cuba.² Newly arrived refugees receive assistance from volunteer agencies to provide orientation, food, clothing, and initial housing with federal government support for the first several months. These federal funds also provide eight months of medical coverage, which serve as a window period for

completion of an initial medical evaluation and consultation from specialists, if necessary. Unlike non-refugee immigrants who must wait several years, refugees can apply for health insurance through the Affordable Care Act (ACA) after arrival and are entitled to apply for permanent resident status (i.e. green card) after one year and citizenship after five years.

The Unique Medical Needs of
Refugees

Refugees come from a range of socioeconomic backgrounds, education and literacy levels, and variable health beliefs, but they share the common experience of being violently uprooted and displaced from their homes. The rates of depression, anxiety, and post-traumatic stress disorder are high.³ Not knowing the whereabouts of their loved ones who were left behind can be an ongoing source of stress and inhibits the healing process. This is further compounded by the challenges of re-establishing a new life in our country without the benefit of language fluency, social capital, and professional credentials. For the vast majority who lack English proficiency upon arrival, the difficulty of communicating and navigating through complex systems such as hospitals, banks, and schools is a constant reminder of their loss of power.

It is recommended that all refugees have a domestic medical evaluation that includes re-screening for tuberculosis; mental health screening; and testing for hepatitis B, anemia, and sexually transmitted infections such as HIV, syphilis, chlamydia, and gonorrhea. The con-

continued on page 9

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Treating Illness in the Context of the Patient's Story: Lessons Learned from a Refugee Health Clinic

Paul Long, MD

Dr. Long is an internal medicine resident at Boston Medical Center.

Needless to say, I did not end up treating my patient's blood pressure that day; rather, I spent the remaining time apologizing and assuring the couple that these medical atrocities do not occur here, only hoping my own encounter with them had not pushed them away from health care altogether.

As a resident in the Immigrant and Refugee Health Program at Boston Medical Center, I have learned that refugees must be treated in the context of their story. To do otherwise is, in many cases, to do harm.

It didn't take long for me to learn this lesson—unfortunately, I learned it the hard way. One of my first patient encounters was with a Mandarin-speaking couple from rural China. They had arrived in the United States a few weeks earlier, and I was the first doctor they had seen here.

I spent the first few minutes traversing their journey to the United States as I mentally checked boxes off in my head: arrival date, departure date, countries visited, etc. They both denied any past medical history. Neither took any medications. The husband had a blood pressure of 172/88, which needed verification. I placed the cuff around his arm and pulled out my stethoscope. By the time my eyes came back to the patient, I was shocked to see tears rolling down his cheeks. I quickly removed the cuff and asked what I had done.

I then learned what I should have learned long before I started examining the patient. They were members of Falun Gong, a religious sect that is reported to have an extensive history of persecution in China.¹ They did not trust physicians. My patient disclosed to me that his brother was killed at the hands of surgeons who illegally harvested his organs for sale on the

black market. They had fled China to avoid a similar fate.

Somewhere between me, my white coat, and a sphygmomanometer, these horrific memories had been conjured up. Needless to say, I did not end up treating my patient's blood pressure that day; rather, I spent the remaining time apologizing and assuring the couple that these medical atrocities do not occur here, only hoping my own encounter with them had not pushed them away from health care altogether. That day, rebuilding trust in the doctor-patient relationship was paramount compared to treating my patient's essential hypertension—something I would have clearly known if I had first taken a thorough social history.

The stories refugees bring with them are amongst the few possessions they have when they first arrive. While the atrocities within these stories do not define the refugees, they often do shape the medical pathologies they may have. More often than not, there is no mutual exclusivity. As healers, we listen to their stories to properly care for them. This point was solidified for me when I met Mr. S, an Afghan refugee.

Mr. S had fled his homeland on the basis of his sexual orientation; he was a gay man in a conservative Muslim family. His journey started in 2002 and had taken him around the world to Norway, back to Afghanistan, and eventually to Pak-

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istan where he applied for refugee status. He was forced to leave his country for fear of death because he had made the bold choice of declaring to his family that he was gay. In response, he was disowned, and his life was threatened.

My first visit with him ended up taking one hour in what was scheduled to be a 20-minute visit. His speech was rushed and his story scattered, a reflection of his generalized anxiety. I could tell that the safety of the clinic room along with my verbal reassurance allowed for a cathartic release with each word he spoke. He praised Allah for the blessings he provided, reminded me he still loved his family, and spoke of a loneliness he felt in his heart. He had no family in the United

continued on page 11

Caring for Refugee and Asylee Torture Survivors in Primary Care

Nicole Chow Ahrenholz, MD; Mahri Haider, MD, MPH; and Anjali Niyogi, MD, MPH

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Case: *An 81-year-old Vietnamese man had been followed for several years for right leg pain, numbness, and weakness that were exacerbated by hunger and insomnia. Labs, imaging, and subspecialty referrals to orthopedics, neurology, and rehabilitation medicine were unrevealing. Eventually he disclosed that he was imprisoned in Vietnam for 22 years, with solitary confinement in tight spaces, starvation, and beatings. At night, guards pulled the shackles around his ankles back and forth to deprive him of sleep. The patient attributed his chronic leg symptoms to his experience of torture in Vietnam.*

Despite international declarations and conventions prohibiting torture, it remains a frequent practice around the world and is an experience shared by many refugees. Torture is defined by Article 1 of the United Nations Convention against Torture as:¹

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain and suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions.

As of 2000, it was estimated that approximately 400,000 torture survivors lived in the United States, and the number is almost certainly much higher now.² In 2014, the United States resettled almost 70,000 new

refugees from around the world—the majority from countries where torture is known to be practiced.³ Prevalence of torture varies widely by the population studied. Surveys at primary care clinics indicate that 6% to 11% of foreign-born participants have a history of torture; 0% of these were identified by their primary care physician.^{4,5} A meta-analysis of 42,626 refugees and other conflict-affected groups showed an overall prevalence of 21%.⁶ As US physicians see greater numbers of refugees, they will need familiarity with taking a torture history and understanding the sequelae of torture and their implications for medical care.

Refugees and Asylum Seekers

A refugee is defined as a person fleeing persecution, which includes abuse, ill treatment, ill usage, maltreatment, oppression, and torture because of race, religion, nationality, political opinion, or membership in a particular social group. As of 2013, an estimated 51.2 million people were forcibly displaced from their homes due to conflict, persecution, and abuses.⁷ Of these, 1.1 million were seeking asylum. The United States is the second leading industrialized country accepting asylum seekers, with 85,000 applications filed in 2013 and more than 300,000 cases pending.⁷

In contrast to refugees, asylum seekers are those individuals who flee their country of origin and apply

for refugee status once arriving in the host country. While refugees are immediately entitled to all resources available to permanent residents, asylum seekers may not have legal status. They are often placed in detention centers and are ineligible for federal benefits while they await a ruling on their claims. As such, they do not qualify for health insurance and may be ineligible to apply for employment.

Asylum seekers face many barriers in seeking medical treatment. In addition to language and cultural differences, they frequently experience economic hardships and the fear of deportation. Furthermore, many survivors are reluctant to disclose their history of torture due to shame or guilt. To attain asylum, a person must prove a well-founded fear or history of persecution. In the United States, only one third of applicants are granted asylum. Medical forensic evidence increases this likelihood threefold (30% vs. 85%).⁸ Formal training in conducting medical and psychological evaluations along with preparing affidavits is available through Physicians for Human Rights.

Medical Care

A past experience of torture, even when remote, can affect medical care. The following factors should be taken into consideration during the initial clinical evaluation:^{9,10}

continued on page 12

A Sudanese Woman with Headache

Michele Fang, MD

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A 57-year-old woman with type 2 diabetes presents with headache and witnessed grand mal seizures. These spells start with the patient staring into space followed by rhythmic whole body jerking that lasts for two minutes and concludes in a post-ictal state. She presents with her son to the emergency department for further evaluation. She was born in Sudan and immigrated to the United States three months prior to presentation.

Seizures are defined as uncontrolled electrical activity in the brain, which may produce a physical convulsion, minor physical signs, thought disturbances, or a combination of symptoms.¹ Causes of seizures include stroke; space occupying lesions in the brain; metabolic encephalopathy (e.g. hyponatremia, hypocalcemia, uremia); drug intoxication from narcotic analgesics, tramadol, and antibiotics (e.g. imipenem, cephalosporines); anesthetics (e.g. enflurane, ketamine, methohexital, local anesthetics); sympathomimetics; and drug withdrawal (e.g. alcohol, benzodiazepines).² The evaluation of seizures centers on the history and physical.

The patient has no head trauma, fever, chills, change in vision, chest pain, shortness of breath, neck stiffness, or altered mental status. She does have bladder incontinence.

Laboratory studies are normal other than a blood sugar of 330. A head CT reveals a right frontal parafalcine meningioma. Neurosurgical consultation recommends prompt admission for management of seizures and resection of meningioma. However, the patient lacks medical insurance and declines admission. The patient is discharged on carbamazepine and instructed to follow up in two weeks.

The patient continues to have seizures. She visits local free clinics for insulin for her diabetes. They usually provide her with regular insulin, but she also requires basal insulin and only receives this if there are samples available. She does not check her blood sugars and has not followed up with neurosurgery or neurology.

Ensuring adequate hospital follow-up and attention to transitions of care are critical to maintaining health. Assurance that the discharge plan has been followed can be especially difficult for many immigrant patients who have limited funds for medications, office visits, and transportation to clinics. Important health literacy, cultural, or language barriers may also lead to further misunderstanding of discharge instructions.

Two years later, the patient presents with a series of three grand-mal seizures within 12 hours and left-sided weakness. Head CT shows

an interval increase in size of the meningioma with vasogenic edema. She is placed on continuous EEG monitoring. The inpatient team starts dexamethasone for cerebral edema and adds additional antiepileptic medications. The patient's HbA1c is 12.3%, and her blood sugars on the dexamethasone are in the 350 to 400 range.

Using a telephone interpreter, as in-person Arabic interpreters are not always available, it is discovered that the patient is no longer taking antiepileptics, having been lost to follow-up. She does not know how to contact physicians for refills. She is only able to obtain basal insulin about 50% of the time but is faithful with her use of regular insulin at mealtimes.

Language barriers can be frustrating for both the patient and medical staff. However, as history plays a critical role in diagnosis and treatment, this barrier must be surmounted. Professional interpreters, whether in person or by telephone or video-conference, should be used whenever possible. In this case, the correct history will ensure that the patient's seizures not be classified as a "treatment failure" with escalation of antiepileptics. In addition, by recognizing that her poorly controlled diabetes may reflect lack of access rather than an inadequate insulin dose, she can be restarted on weight-based insulin dosing to avoid hypoglycemia.

On resumption of carbamazepine, the patient no longer has seizures. She wears EEG leads under her traditional Hijab (i.e. head scarf). She also has difficult-to-control blood sugars with the dexamethasone, especially in the evenings, and low blood sugars in the late mornings. On further investigation, the patient disclosed that she was fasting for Ramadan.

continued on page 14

Immigrants who are eligible for coverage through the Health Insurance Marketplace include those immigrants who have qualified for non-citizen immigration status without a waiting period as well as immigrants with humanitarian status or circumstances, valid non-immigrant visas, and legal status conferred by other laws.⁴

Undocumented Immigrants with End-stage Renal Disease: The Case for Dialysis

Lilia Cervantes, MD; Philip Fung, MD; and Stacy Fischer, MD

Dr. Cervantes is an assistant professor and Dr. Fischer is an associate professor of medicine at the University of Colorado School of Medicine. Dr. Fung is an assistant professor of medicine at Saint Louis University School of Medicine.

Carmen was a 32-year-old Mexican woman with two elementary school-aged boys who first presented to our emergency department after six months of worsening nausea and vomiting, confusion, fatigue, and eventually shortness of breath. We discussed next steps with Carmen shortly after her stay in the intensive care unit, where she had been emergently dialyzed for a new diagnosis of end-stage renal disease (ESRD). The content of our conversation was unfortunately not unique and one we have too often at our safety net hospital. Carmen was undocumented. As she sat in her hospital bed with a tunneled catheter and the whirr of the dialysis machine in the background, we spoke about kidney failure and dialysis. We described the purpose of the kidney and how the machine would take the place of her kidneys by cleaning out her blood. We then spoke about how her undocumented status precluded her from receiving the standard of care. We went on to say that in Colorado undocumented patients with ESRD do not qualify for routine dialysis and that she would need to come in weekly when she felt ill enough to meet clinical criteria for admission to our hospital for emergent inpatient dialysis.

There are an estimated 11.2 million undocumented individuals in the United States with the majority being Latino and the largest subset being Mexican (52%).¹ Latinos have a nearly twofold higher incidence of ESRD compared to non-Latino whites, and there are an estimated 6,480 undocumented individuals with ESRD in the United States.^{2,3} US citizens have access

to care under the 1972 law that established the Medicare ESRD program. If ineligible for Medicare, patients can receive coverage through Medicaid. Medical care for the undocumented with ESRD is fragmented and inconsistent across states.⁴ Under the 1986 Emergency Medical Treatment and Labor Act (EMTALA), undocumented individuals could not receive medical assistance unless they had an emergency medical condition. EMTALA is interpreted differently by each state and sometimes by individual hospitals within a state. For example, one state may consider the diagnosis of ESRD an emergency and provide dialysis care three times a week; in a neighboring state, a patient with ESRD may need to be critically ill (e.g. potassium greater than 6.0) before his/her care is considered an emergency. In addition to dialysis, there is a spectrum of what is offered with respect to primary ESRD care (e.g. treatment of anemia and hypertension) and dialysis access (e.g. arterio-venous fistulas vs. a tunneled catheter, which increases the risk of infection).

It was several months before Carmen understood that the care she received differed from those who were routinely dialyzed in the outpatient setting. Week after week, she presented to our emergency department with her two boys. Over the next six months, she became withdrawn and cried during her dialysis sessions. We came to understand that Carmen's only support had been her father, who was deported weeks after she was diagnosed with ESRD, leaving her homeless. In addition to depression, Carmen had a substantial

symptom burden and expressed a desire to withdraw from dialysis.

Patients with ESRD suffer a substantial symptom burden that is similar to that experienced by patients with advanced cancer and end-organ failure (e.g. heart failure, liver failure), including fatigue, decreased well-being, loss of appetite, and pain. There is very little research on Latinos with ESRD, and to our knowledge, there is no research on palliative care in undocumented individuals with ESRD. The available palliative care research on Latinos with other advanced illnesses suggests that compared to non-Latino whites, Latinos are less likely to die at home according to their wishes,^{5,6} less likely to have adequate pain management,⁷⁻⁹ and less likely to report a conversation about advanced directives.¹⁰

We gathered a multidisciplinary team and over the next two years effectively treated Carmen's depression and pain, helped her find stable housing, and began conversations about her values and goals. She was firm about her decision to withdraw from dialysis. She reasoned that she never wanted to be on dialysis but felt that there was no other option because stopping dialysis meant death and she did not want her children to be lost in the US foster system. She described having just one to two days each week during which she had enough energy to spend quality time with her boys. She had survived three cardiac arrests and lived each day with the fear of another cardiac arrest that would break additional ribs and leave her eldest son even more emotionally traumatized.

continued on page 15

SGIM and Advocacy: Coalition for Kidney Care of Non-Citizens (CKCNC)

Liam Howley, MD; Matthew DeCamp, MD, PhD; Maura George, MD; and Donte Shannon

Dr. Howley is an assistant professor of clinical medicine at the Indiana University School of Medicine, Dr. DeCamp is an assistant professor of medicine at the Johns Hopkins Berman Institute of Bioethics and the Division of General Internal Medicine, Dr. George is an assistant professor of medicine at Emory University, and Mr. Shannon is manager of volunteer services at SGIM.

In this issue of *Forum*, Lilia Cervantes, MD, and colleagues write eloquently about a patient with end-stage kidney disease who is unable to obtain regular dialysis care due her undocumented immigrant status and instead requires emergent hemodialysis every week. How far from standard of care is such treatment, especially in light of evidence that even the traditional two-day interdialytic interval is a time of increased risk for patients receiving hemodialysis three times a week?¹ In addition to dialysis, renal transplantation would be the standard of care for such patients were they not undocumented immigrants.

Motivated by the fundamental ethical dimensions of this tragic situation—including the human right to health care, fairness, and choice and physicians' obligations to their patients—the SGIM Ethics Committee formed a subcommittee in 2013 to

examine how individual physicians, professional societies, and others should respond. Recognizing the inherently multidisciplinary nature of the problem, the subcommittee quickly reached out to other important stakeholders, including nephrologists, public health figures, ethicists, advocates, and social workers across the country. This resulted in the Coalition for Kidney Care of Non-Citizens (CKCNC) whose first task was to craft a position statement on care for the undocumented population with advanced kidney disease.

The CKCNC statement builds on existing position statements from the Renal Physicians Association (RPA) and American College of Physicians (ACP).² It is, however, uniquely a product of its diverse stakeholders. Indeed, the process of writing the statement was itself used to build and solidify the CKCNC for advocacy and awareness purposes. The state-

ment, which has not been endorsed by SGIM formally, is presented in Table 1.

What is the role of SGIM and its members related to this statement? As the statement continues to be revised, the CKCNC hopes to present it to SGIM and other relevant organizations and societies for formal endorsements. For individual members, the statement seeks to raise awareness of this issue, to reassure members who experience this issue firsthand that they are not alone, and to make clear physicians' and the profession's ethical obligations in response. Although our membership is diverse, and we may not agree on immigration policy, few would suggest that immigration status should interfere in the patient-physician relationship.

We have learned several lessons through this process. First, coalition

continued on page 16

Table 1. Coalition for Kidney Care of Non-Citizens Statement

Preamble: The right to health care is an internationally recognized human right due to its fundamental impact on the individual's abilities to participate in the political, social, and economic life of society. This statement focuses specifically on the undocumented population of immigrants, as this is a topic of debate currently in the United States and a growing problem for health care systems across the country.

1. There is a collective ethical obligation amongst health care professionals and health care systems to ensure access to standard medical care (including as an example maintenance dialysis and transplant for patients with end-stage kidney disease) to individuals regardless of citizenship status, ethnic origin, nationality, native language, legal or social standing, or economic means.^{1,2}
2. Physicians should, individually and collectively, advocate for public and charitable funding programs to eliminate financial barriers to medical care. All physicians should fulfill their social responsibility for delivering high-quality health care to those without the resources to pay.³
3. Physicians should uphold patient confidentiality and should not report non-medical information about the documentation status of undocumented non-citizens to the authorities.
4. Physicians should, individually and collectively, work with all relevant stakeholders including patients, policy makers, health insurers, and health care systems to ensure, within the best of their abilities, that health resources are justly distributed amongst all.

¹ Adapted from the Declaration of Geneva <http://www.wma.net/en/30publications/10policies/g1/>

² Adapted from the American Medical Association's Health and Ethics Policy H-160.987 Access to Medical Care

³ AMA Principle 3-6b: All health care facilities and health professionals should fulfill their social responsibility for delivering high-quality health care to those without the resources to pay.

EDITORIAL

continued from page 1

first hundred years. Only later did the United States establish a quota system, which can be viewed either as a mark of success and maturity in a nation or something far less benevolent.

The composition of new arrivals to this country subsequently has been decided by numerous legal and political factors: laws relating to immigration quotas, protections for refugees and asylum seekers, and undocumented arrivals; geopolitical conditions in other countries; and the ease of travel between other nations and the United States. (My own parents are an example of just some of these varied paths. After the end of the 60-year period of complete exclusion of Chinese immigrants to the United States, one arrived as a refugee and the other as a student.) World upheavals and the political battles surrounding immigration in state houses and national political races seem ever present and likely to continue.

Into this whirlwind come you and I as health care providers facing the complex challenges of immigrant health, which are brilliantly illustrated in this informative, inspiring, and thought-provoking issue of *Forum*. For the many educators in SGIM, Drs. Terasaki and Annamalai discuss the medical evaluation of refugees and the value of

resident education. Dr. Long follows this with a first-hand perspective as a resident in a refugee clinic in Boston. Next, Dr. Ahrenholz and colleagues provide guidance on the care of refugees and asylum seekers who are survivors of torture.

What about advocacy? Our morning report case by Dr. Fang highlights the impact of inadequate access to care on the health of a recent immigrant. The American College of Physicians (ACP) approved a position paper in 2011 that recommended a comprehensive national immigration policy with improved access to health care for immigrants, including the undocumented.² Many SGIM members took part in protesting a proposed restrictive state bill during the SGIM 2011 national meeting in Arizona.³ Is advocacy for the undocumented poised to go a step further? Will SGIM and its membership embrace this challenge? Dr. Cervantes and colleagues advocate for dialysis in the undocumented—both from an ethical and a cost-saving standpoint. A subgroup of SGIM's Ethics Committee formed the Coalition for Kidney Care of Non-Citizens (CKCNC), which takes this concept one step further: Why not organ transplantation in addition to dialysis? They present their recommendations to

the SGIM community for comment, and I encourage you to review and discuss the draft position statement with your colleagues and leaders.

As clinician-educators, researchers, policy makers, patient advocates, and SGIM volunteers, take a moment to reflect on the issue of immigrant health and how we as a society can create a better safety net for all.

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NEW PERSPECTIVES

continued from page 2

Communication Skills
Appropriate use of interpreters
Sensitivity to past traumatic experiences
Sensitivity to differing attitudes toward health and illness
Orientation to a new health care system
Screening Examination
Screening for infectious diseases (e.g. parasites, tuberculosis, hepatitis, sexually transmitted diseases including HIV, malaria)
Assessing immunization status by records and lab titers
Screening for chronic disease (e.g. undiagnosed nutritional deficiencies, common conditions such as diabetes and hypertension)
Screening for mental illness
Longitudinal Care
Counseling on preventive care
Chronic illness management (e.g. diabetes, hypertension)
Care of somatic manifestations of mental health problems
Collaborative management of post-traumatic stress disorder (PTSD), depressive disorders
Advocating for patients on health, social, and legal issues
Helping patients navigate subspecialty care
End-of-life care

tent and depth of this initial evaluation varies by state and county—one should not assume that refugees have previously received a complete medical evaluation. Given the harsh living conditions before resettlement—with inadequate health care, sanitation, and access to safe water—refugees are at risk for parasitic diseases. If overseas documentation of presumptive treatment with anti-helminthic agents is not available, primary care providers should consider the possibility of asymptomatic infections, especially *Strongyloides stercoralis* and *Schistosoma* species, both of which can persist sub-clinically for years after immigration and lead to complications.⁴ Additionally, refugees also require age-appropriate vaccination series or, in the case of hepatitis A and varicella, serologic evidence of immunity. Hepatitis B testing should also be done before vaccinating to identify those with current infection.⁵

Resident Education in Refugee Health

Caring for refugee patients is immensely rewarding as it expands

our capacity to listen, communicate, and advocate. Clinics that serve refugees provide a rich educational environment where medical residents learn the importance of the initial screening examination, common medical conditions, the social and historical context affecting health, and the work required to build trust across differences in language, power, and culture.

From the beginning of resident training, we teach strategies to work effectively with interpreters and optimize communication. Misunderstandings can occur between people speaking the same language; when using an interpreter, linguistic imprecisions can be magnified. Even a simple statement about “dizziness” may have several meanings, and the interpreter has to decide which one is the intended message. For example, should an interpreter translate the Cambodian word “krun” as fever or as feeling generally unwell? What are the clinical implications when an interpreter uses a different word for tuberculosis or cancer in an attempt, consciously or subconsciously, to change the tone? We stress the im-

portance of taking the time to confirm the understanding of both patient and provider through summarizing and rephrasing critical parts of the discussion. Changing or prescribing a new medication can be confusing, so we employ the “teach-back” method to ensure the patient’s comprehension.

To build trust, we emphasize that patient encounters go beyond diagnosing and prescribing—not unlike any medical encounter. However, in the refugee clinic, additional time and skill may be required to listen, explore the social context, and demonstrate a sense of equity and compassion. Awareness of a torture history can help prevent traumatization by showing sensitivity when performing tests such as phlebotomy, electrocardiograms, pelvic exams, and magnetic resonance imaging (MRI) scans. Many of our patients come from regions of the world where primary care is non-existent and chronic diseases are not addressed. The notion of taking a long-term pill to reduce the risk of a future complication is abstract. We

continued on page 10

NEW PERSPECTIVES

continued from page 9

often need to extensively educate patients regarding the need to treat asymptomatic conditions such as hypertension. Similarly, we grapple with preventive health recommendations. For example, how do we appropriately explain the potential survival benefit of a screening mammogram to a refugee patient who, in her lifetime, has survived unimaginable danger?

In addition to developing communication skills and cultural sensitivity, educational curricula for residents should include core clinical topics relevant for refugee care (Table 1). Clinical learning can occur in varied settings. We describe two examples of resident refugee clinics below.

Screening Clinic: Yale Refugee Clinic, Yale University, New Haven, CT

The “Yale Refugee Clinic,” part of Yale New Haven Hospital (YNHH), was started in 2009 in an effort to provide timely medical screening for refugees soon after arrival into the country. It is a resident-led clinic, and second- or third-year residents from the Yale internal medicine program interested in global health take on leadership roles. We have a strong relationship with the local resettlement agency, and all patients are brought to the clinic within four weeks of arrival. Our team consists of an attending physician, nurse, resident physician leaders, interns, a volunteer psychiatrist, and psychiatry and psychology fellows. In each half-day clinic, three to four new refugees are seen for an intake evaluation under the supervision of an attending with expertise in refugee health. Urgent follow-up issues are addressed within the confines of this clinic. The residents performing the evaluations then add these patients to their primary care panel and continue to see them for the remainder of their training at their primary care site whenever possible. Our clinic sees a large number of patients from the Middle East, reflecting trends in refugee arrivals. We have in-person interpreters for

most languages in the clinic in addition to a phone interpreter service.

The focus of learning within this clinic is screening for undetected or poorly treated chronic illness, infectious and communicable diseases, mental illness, and somatic manifestations of mental health problems. We also provide counseling on preventive care and orient refugees to a new health care system. Even simple instructions such as returning to the pharmacy for a medication refill without a repeat physician visit can be difficult to understand for many refugees with limited language skills and lack of exposure to similar health systems. We encounter many chronic conditions including chronic pain, diabetes, hypertension, depression, and psychiatric symptoms resulting from trauma.

Continuity Clinic: International Medicine Clinic, Harborview Medical Center, Seattle, WA

Harborview’s “Refugee Clinic” was originally founded in 1982 in an effort to screen and treat Southeast Asian refugees for intestinal parasites. The clinic gradually expanded to become a full-time primary care clinic, providing nearly 12,000 patient visits annually in more than 30 languages. In 1995, it changed its name to the International Medicine Clinic to recognize its expanded role in the community of global medicine. Over the past 30 years, the clinic’s patient demographics have shifted, reflecting the current geopolitical situation and migration. While we still see many of the original Vietnamese, Mien, and Cambodian patients, we now have many patients from the Horn of Africa, Central America, China, and Afghanistan. Our newest patients continue to be refugees from East Africa, but we are increasingly seeing more people escaping from the conflicts in the Middle East and Burma. Like the Yale Clinic, we rely on in-person interpreters for the most prevalent language groups (i.e. Somali, Amharic, Vietnamese, Cambodian, Tigrinya, Oromo, and Span-

ish) as well as telephonic language services. In addition, we have an on-site dispensing pharmacy, clinical pharmacist, integrated mental health providers, dietitians, and social workers.

Nine internal medicine residents care for a panel of patients as part of their continuity clinic. While we do have patients with infectious diseases, such as strongyloides and tuberculosis, the vast majority of patient diagnoses are fairly typical of primary care: acute cough, headaches, and low back pain as well as chronic conditions such as diabetes, hypertension, asthma, heart failure, cirrhosis, depression, and arthritis. Patients frequently raise concerns about non-medical issues (e.g. transportation, housing, citizenship, legal issues), and our residents quickly gain proficiency at juggling competing agendas while utilizing the clinic social worker. Similar to other resident clinics, our pre-clinic conferences cover most of the primary care topics but within the context of our patient population and its unique needs.

Conclusion

Caring for refugees in the primary care setting is a highly rewarding learning experience for any resident but especially those with an interest in global health, cross-cultural care, and psychiatric integration in primary care. For some patients, this may be the first time they establish a longitudinal relationship with a health care provider, so residents enjoy the experience of being a patient’s “first doctor.” Residents have reported increased sensitivity to the lives of refugees and their difficult journey, and this adds a new dimension to cultural awareness. Many refugees are resilient and do eventually heal their wounds, both physical and psychological. Residents find it gratifying to practice supportive and compassionate medical care to help improve the lives of people coming from extraordinarily difficult circumstances.

continued on page 11

NEW PERSPECTIVES

continued from page 10

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SGIM

ESSAY

continued from page 3

States and had made no friends since arriving. His depression and anxiety contributed to chronic headaches and whole body pains—a somatization common to refugees.^{2,3} He had been resettled in a house with other Afghan men. Fearing they would find out he was gay, he spent most of his time walking around Boston alone.

I continued to see Mr. S on a monthly basis. I prescribed an antidepressant, but his story in its entirety provided much more clarity in what his treatment need to be—he needed a community to belong to. With the help of colleagues in our program, we identified a clinic in Boston with a support group for homosexual refugees, which has ultimately become a safe haven for him. While he now sees a primary care doctor at that clinic, he still chooses to meet with me every few months. I am responsible for no medications. My only therapy is to listen to him. With each visit his story of freedom becomes more emboldened.

I have found that the diversity of refugees' stories ranges as wide as the countries from which they come and the illnesses they have. There is the Iraqi who served as a translator for US Marines, eventually forced from his homeland and family because he selected this job. He battles insomnia and post-traumatic stress disorder. There is the computer engineer from Eritrea who re-

fused to join the Eritrean military and was subsequently sentenced to solitary confinement only to escape via the Sudan desert to Egypt. He has latent tuberculosis. There is the Haitian asylee who fled to avoid domestic abuse, was detained at the Mexico-US border, and who was eventually flown to Boston. She has functional abdominal pain as a result of her trauma. The stories go on—all of them powerful and unique—and show how the past can affect the assessment and treatment of their illnesses.

As clinicians in today's medical climate, we often redirect our patients during their storytelling, summarizing entire social histories in three minutes or less. Our patients become a name, age, and a litany of medical problems. The humanity of their personal journey gets reduced to checked boxes for housing and smoking status. The most profound lesson I have learned during my time treating refugees is that I must not do this. I am a significantly better healer—and ultimately more efficient—when I take the time at the beginning of a new patient encounter to quietly listen and feel the true pulse of my patient's presenting story.

In addition to individual healing, stories provide insights and opportunities to advocate for our patients. For refugees, these may include a myriad of issues such as religious freedom, tolerance of ethnic diver-

sity, gay rights, and gender equality. The sharing of these stories can become a powerful form of advocacy by providing personal accounts of the intolerance that is bludgeoning entire people groups around the world.

Lastly, I have found that listening to refugees' stories helps me heal. They allow me to replace the grimness of health care disparities and global tragedies like the current state of Syria with a face of hope. By listening, I am privileged to bear witness to a recurring narrative of courage and human endurance.

For all of these reasons, as clinicians we must take the time to understand our patients' health in the context of their stories. This is how we will best treat them, advocate for their causes, and help heal the world around us.

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SGIM

SIGN OF THE TIMES

continued from page 4

1. *Taking a torture history.*¹¹ Relevant history questions are shown in Table 1.
2. *Physical sequelae.* US physicians who care for refugees will encounter the long-term physical sequelae of torture, which vary by the type and severity of torture performed (Table 2). Beatings and blunt trauma can result in poorly healed fractures and traumatic brain injury, with effects on memory, executive function, and mood. Falanga, or beating the soles of the feet, can cause subcutaneous fibrosis, resulting in chronic pain and gait abnormalities. Survivors of electrical torture may have characteristic burns or neuropathy.

While some survivors of torture have scars or visible deformities, others lack visible evidence of torture but still suffer from chronic debilitating pain. Knowledge of a patient's history of torture can sometimes help explain atypical pain complaints, as described in the case on page 4.

3. *Psychological sequelae.* The psychological effects of torture can be more debilitating than the physical sequelae. Mental health disorders occur frequently in survivors of torture, with 81% having clinically significant anxiety, 85% clinically significant depression, and 46% symptoms of post-traumatic stress disorder (PTSD). Often a patient's psychiatric symptoms can wax and wane depending on other medical or life stressors:

A 65-year-old Cambodian gentleman with a history of diabetes and chronic kidney disease began to experience nightmares and poor sleep when he was told he needed dialysis. He revealed that he was having frequent nightmares about when he lived in a labor camp under

Table 1. Taking a Torture History

What made you leave your home country?

In your home country, did you ever have problems because of religion, political beliefs, culture, or any other reason?

Did you have any problems with persons working for the government, military, police, or any other group?

Were you ever a victim of violence in your home country?

How did you get this scar?

(Adapted from Walker PF, Barnett ED. Immigrant Medicine, Table 48.2, reprinted with permission)

the Khmer Rouge. He viewed his dependence on dialysis as a type of confinement, where his freedom was once again being limited. With attention to the narrative behind his symptoms, he was able to get effective treatment for his PTSD and eventually was willing to start dialysis.

4. *Retraumatization by the medical setting.* Many patients who have been subjected to torture are reluctant to discuss their experience, and clinicians may fear retraumatizing patients by inquiring about their past. However, not knowing a patient's history of torture has the potential for even greater retraumatization. The medical setting can bring back painful

memories, as torture often has medical overtones (e.g. performing procedures, administration of drugs including psychoactive compounds, and physician participation in the act of torture). Lying still in a loud MRI scanner can evoke claustrophobia and panic in a person who has been subjected to forced postures or imprisonment in confined spaces. Being connected to ECG leads or EMG needles can provoke flashbacks of electrical torture. Many of the routine practices that occur in the clinical setting can trigger memories of past torture:

A 53-year-old Cambodian woman with diabetes had a meeting with
continued on page 13

Table 2. Common Methods of Torture

Physical Methods

- Blunt trauma (e.g. beatings all over; "falanga", beating the soles of the feet; "telefono", striking the ears)
- Penetrating trauma (e.g. cutting, amputations)
- Crushing trauma
- Positional torture (e.g. suspension, confinement in small spaces, fixation by ropes or chains)
- Shaking
- Asphyxiation
- Chemical torture
- Burns (e.g. electrical, acid, cigarettes)
- Pharmacologic or microbiologic torture (e.g. forced ingestion of medications, inoculation of pathogens such as HIV)
- Sexual torture

Psychological Methods

- Humiliation (e.g. mocking, sexual humiliation, forced breaking of religious taboos)
- Threats
- Mock executions
- Deprivation... of light and sound of food and drink of access to toilet facilities of sleep of company of access to medicine and medical care
- Witnessing or perpetrating the torture of others

(Adapted from Walker PF, Barnett ED. Immigrant Medicine, Table 50.2, reprinted with permission)

SIGN OF THE TIMES

continued from page 12

a nutritionist to discuss diet and weight loss that triggered memories of food deprivation and watching her children die of starvation during the Khmer Rouge.

A 32-year-old Chinese woman presented to clinic requesting removal of her intra-uterine device (IUD). Upon further questioning, she revealed that when she was in China and pregnant with her second child, she was forced to undergo an abortion and placement of an IUD in accord with the One Child Policy. Knowledge of her past torture allowed the physician to anticipate the retraumatization that might occur during an IUD removal and take the time to adequately prepare the patient.

5. *Nonadherence.* Closely tied to the issue of retraumatization is the problem of nonadherence. The act of torture robs a person of control and renders him/her powerless. For many torture survivors, encounters with the US health care system create many of the same feelings of powerlessness, which can lead to lack of follow through with appointments, labs, studies, or referrals.

A 73-year-old Oromo man was seen for recurrent episodes of cerumen impaction in his right ear but repeatedly failed to present to nurse appointments for irrigation. He later revealed a history of torture including "telefono" (i.e. repeated striking of his ears) that occurred around 40 years ago in Ethiopia when he was advocating for political rights of the Oromo population. He reported fearfulness about ongoing damage to his ears and lack of control during irrigation or manual disimpaction. Once his history of torture was known, his physician was able to negotiate management strategies that

allowed the patient more control over his care, such as applying his own eardrops at home.

Summary

Torture unfortunately remains prevalent in many parts of the world and is an experience shared by thousands of immigrants and refugees. Awareness of a patient's torture history can allow physicians to understand the background of certain physical and psychological symptoms, anticipate and prevent retraumatization, troubleshoot barriers to adherence, and further a path to healing.

Suggested Reading

<http://www.healtorture.org/>
<https://www.healthright.org/>

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The United States is the second leading industrialized country accepting asylum seekers, with 85,000 applications filed in 2013 and more than 300,000 cases pending.⁷

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MORNING REPORT

continued from page 5

Before making adjustments to insulin, it is critical to discuss the patient's current dietary pattern. Ramadan is a month-long period in which practicing Muslims refrain from eating, drinking, and smoking from dawn until sunset. Food and drink are served daily before dawn and after sunset for one month. The month of Ramadan follows the lunar calendar and therefore starts at a different date each year. Sliding scale insulin will only provide correction for current glycemic states, while basal insulin provides consistent levels of blood glucose during periods of fasting. It is the mealtime or nutritional insulin that is variable in this patient. As her breakfast, lunch, and dinner intake was nil, she required no mealtime insulin at these times; however, she ate a large late evening meal and required a more substantial preprandial dose of insulin at this time.³

If the patient had medical insurance and could ensure close follow-up, she would have been discharged for meningioma resection in the next one to two weeks. Given concerns for adequate follow-up, the patient is hospitalized until the next available surgery date three days later.

The Affordable Care Act (ACA) has improved access to health care. Residents who live in the United States and are US citizens or US nationals and are not incarcerated are required to have health insurance.⁴ According to healthcare.gov, most immigrants who are "lawfully present" qualify for health insurance. Immigrants who are eligible for coverage through the Health Insurance Marketplace include those immigrants who have qualified for non-citizen immigration status without a waiting period as well as immigrants with humanitarian status or circumstances, valid non-immigrant visas, and legal status conferred by other laws.⁴

Immigrants also gain health care coverage under the ACA with Medicaid expansion. Expanding Medicaid eligibility to nearly all low-income adults with incomes at or below 138% of the federal poverty level

(FPL)—\$16,242 per year for an individual in 2015—allows many lawfully present immigrants to gain coverage.⁵ In addition, the Supreme Court ruling on the ACA's constitutionality effectively made the expansion a state option. As of February 2015, 29 states and the District of Columbia are implementing the expansion.⁴ Iowa is one of five states that has received approval of a Section 1115 waiver to implement the Medicaid expansion; Arkansas, Michigan, Pennsylvania, and Indiana have as well. These waivers allow the states to implement the Medicaid expansion in ways that do not meet federal rules and still access enhanced federal matching funds for newly eligible adults.⁴

This patient obtains green card status—ironically, her son works at the hospital—but she does not know how to apply for health insurance and has missed the enrollment period. Social service providers work with the family but have little to offer her until the next enrollment period starts on November 1, 2015, for coverage in 2016.

Many immigrant families are of "mixed status," with members having different immigration and citizenship statuses. For example, some families may have taxpaying members who cannot buy health insurance through the Marketplace while other family members are eligible to use the Marketplace as citizens or lawfully present immigrants. The ACA states that family members who are not applying for health coverage for themselves will not be asked if they have eligible immigration status.⁴

The patient does well after surgery and has no recurrence of her seizures. She is discharged on basal/bolus insulin. Follow-up in two weeks is recommended at the local free clinic for management of blood sugars while dexamethasone is tapered. Unfortunately, the free clinic does not take "appointments" but is rather a first-come, first-served clinic. The patient stands in line for two hours prior to the clinic opening

to try to ensure that she is seen that day. Glargine insulin in the hospital repository from patients donating unused medications is given to the patient for use upon discharge. Further supplies of insulin are ordered via the glargine insulin patient assistance program after arrangements are made for the free clinic physician to serve as her primary care physician. The patient follows up with neurosurgery after six weeks as recommended. She has a follow-up head CT and office visit, which she pays for out of pocket. The patient will enroll for insurance (likely Medicaid) with her son's help via the ACA on November 1, 2015. At that point, basic health maintenance such as mammograms, screening lipids, colonoscopy, cervical cancer screening, and diabetic eye exams will need to be initiated. With medical coverage for prescription medications and diabetes testing supplies, the patient will have access to medication to prevent further seizures and improve her blood sugar control. She will also receive preventive therapy, including an ACE inhibitor for prevention of renal complications.

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COMMENTARY

continued from page 6

tized because he was the person who always called an ambulance. The home we found for Carmen and her boys had legal services, and with their assistance, we worked with several adoption agencies until Carmen selected the parents that would eventually adopt her boys. Her last wishes were to spend time in the Rocky Mountains with her boys and foster parents and then travel to Mexico to die with her father caring for her. She passed away two years ago.

Many believe that the inconsistent care we offer this marginalized and vulnerable group is unethical.³ These patients are treated differently and below the standard of care because of their immigration status. While it is beyond the scope of this article to delve into all of the ethical arguments concerning the provision of health care for undocumented immigrants, a compelling argument can be made that while these individuals are not citizens, they remain a part of society, albeit often at the margins. Not addressing their needs is a way of ignoring their part in society and keeping them marginalized.¹¹

Other more practical arguments support routine hemodialysis for undocumented individuals with ESRD. Emergent care is 3.7 times more expensive than routine care.¹² The undocumented immigrant community is stable and does not migrate to the United States specifically to access medical care.¹³ From a financial perspective, undocumented immigrants contribute significantly more money from unclaimed W2 taxes than the amount estimated to provide them with routine ESRD care.¹⁴ In contrast to the Centers for Medicare and Medicaid Services (CMS), which has implemented patient-centered quality measures into their value-based purchasing program (i.e. ESRD Quality Incentive Program),¹⁵ care has not changed for undocumented immigrants with ESRD, and there is little national

leadership amongst nephrologists to improve their care. Our clinical experiences caring for Carmen and other similar patients have informed our ongoing research with this population. We are now conducting research that will provide a more in-depth description of the illness experience of undocumented Latinos with ESRD. This research includes a comparison of outcomes and utilization between undocumented emergently dialyzed ESRD patients and undocumented ESRD patients who receive routine dialysis. An observational cohort survey of documented and undocumented Latinos will help us understand their palliative care perspectives. Ultimately, we aim to develop a patient navigator intervention that will be culturally tailored to Latinos undergoing both routine and emergent hemodialysis to improve their palliative care outcomes.

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FROM THE SOCIETY

continued from page 7

building is challenging. Coalition members have different priorities and constituencies that make achieving unanimous agreement difficult. However, collaboration resulted in a final product that has been created and endorsed by coalition members whose relationships were forged in the process. Second, it takes patience. This sustained effort has occurred over nearly two years with ongoing support of the SGIM Ethics Committee, and it has been driven primarily by the passionate commitment of its subcommittee members. Third, collaboration is a worthwhile and exciting undertaking when common interests in advocacy are well aligned.

The CKCNC recognizes that care of advanced and end-stage kidney disease is only a small part of a bigger issue. Its longer-term goal is to change national policy regarding not only renal transplantation but also the more general issue of medical care for non-citizens. Immediate future efforts of the CKCNC, supported by the Ethics Committee, consist of ongoing revision of the position statement (including development of a formal and more comprehensive white paper), a national survey of current practices regarding health care for noncitizens with end-stage kidney disease, and continued coalition building with other organizations and stakeholders.

We hope SGIM members will support our statement and help our cause. If you are interested in joining CKCNC in our advocacy and research efforts, or if you know of an organization that would make a good partner for our coalition, please email Donte Shannon at shannond@sgim.org.

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SGIM

SGIM ANNUAL MEETING
2016 HOLLYWOOD, FL
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IMPORTANT DATES

Call for Workshops, Updates and Interest Groups

September 9, 2015: Online Submission Opens (target date)

September 28, 2015: 9:00 AM Eastern Time - Early Submission Fee Period Ends

October 13, 2015: 9:00 AM Eastern Time Submission Deadline

Call for Scientific Abstracts, Clinical Vignettes, Innovations in Clinical Practice and Innovations in Medical Education

November 18, 2015: Online Submission Opens (target date)

December 13, 2015 at 9:00 AM Eastern Time: Early Submission Fee Period Ends

January 13, 2016 at 8:59 AM Eastern Time: Submission Deadline

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