Season 4 Episode 5
Immigrant Health
Transcript

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[0:00-0:51] Welcome and Introductions

RC: Welcome to the DEI Shift, a podcast focusing on shifting the way we think and talk about diversity, equity, and inclusion in health care. My name is Dr. Ricardo Correa, a fellowship director for Endocrinology, Diabetes, and Metabolism, and the director for diversity and graduate medical education for the University of Arizona College of Medicine Phoenix, and we will be your co-hosts for this episode.

BV: And my name is Brittane Valles. I am an internist who has a strong interest in medical education and promoting wellness, and so on my days off, you'll often find me hiking in the Sonoran Desert. As your co-hosts today, we are delighted to talk to you about migrant health.

[0:51-2:25] Introducing Guest Dr. Lorena Del Pilar Bonilla

RC: Let's introduce our guest, Dr. Lorena Del Pilar Bonilla. Dr. Bonilla is a first generation Ecuadorian American born and raised in New Jersey. She earned her Masters in Science degree in Cell and Developmental Biology from Rutgers University and Doctor of Medicine from University of Colorado School of Medicine. She completed her internal medicine residency training at Brown University and Rhode Island Hospital and works as a hospitalist in Florida. She is an Assistant Professor at Florida University/Herbert Wertheim College of Medicine and a Regional Advisor to the Southeast Regional Latino Medical Student Association (LMSA).

Dr. Bonilla is passionate about wellness, addressing healthcare disparities, mentoring students, and using her clinical expertise to advocate for vulnerable immigrant communities. She is also a co-founder of Doctors For Camp Closure in Florida which started in 2020.

Dr. Bonilla, welcome to The DEI Shift. We often use first names on the DEI Shift. Is it okay if we call you by your first name?

LB: Absolutely!

RC: Thank you so much for that.

BV: Yes, and so let's transition to our next segment called, "A Step in Your Shoes".

[2:25-3:32] "A Step in Your Shoes" Segment

RC: In this segment, we ask our guests to share an element of their background or culture that has been important in their life. This could be anything from a type of food or drink, a song, poem or life experience. The goal is not only to get to know our guest, but also to build cultural competency and humility. With that said, what would you like to share with us today, Lorena?

LB: So a little bit about myself is that I started running in the outdoors to enjoy nature back in high school. And I've kept up with that habit; it's a lot of fun. And then in my adulthood, I incorporated meditation, so I use running and meditation to rejuvenate myself.

BV: That's great, thank you so much for sharing.

[3:32-4:28] Introduction on Immigrant Health

BV: So Lorena, we're so glad to be able to speak with you today on this topic of migrant health. In 2019, the UN International Migration Report estimated that there were 272 million international migrants worldwide, 59 million in Northern America. While COVID has disrupted migration around the globe, the United States still remains one of the largest destinations, hosting 51 million international migrants as of 2020, which is about 18% of the world's total migrants.

This topic is important as many physicians in our country may take care of immigrants in their practice. So today we're going to talk about issues that immigrants face with respect to healthcare and the things that we should be mindful of. So just to start off, Lorena, we would like to hear from you, what inspired you to have the passion to work with patients who are immigrants?

[4:28-7:11] Dr. Bonilla's Story of Inspiration

LB: So I'm gonna tell you a story and I would like for you to kind of visualize a young 14 year old girl who went to her ophthalmologist for her annual exam. So she's at the office with her mom and the ophthalmologist, and the exam has concluded. And because the mom cannot speak English, the ophthalmologist gives the information to the 14 year old girl and says, "Please tell your mom that your vision is very poor and that you may be visually impaired in your young adulthood." And this 14 year old had to translate that to the mom, but she decided to say instead, let me withhold that information and tell mom, "Mom, I need glasses. I'll need to see the ophthalmologist next year.

So I was this 14 year old young girl that had to translate for my mom because my mom didn't speak English. And we often find in immigrant families that the young people, as myself, have to be translators in healthcare situations.

That is one lesson that we can learn from this story, including myself, is that there's a language barrier, and medical facilities should actually have translation services so that a child is not being used as a translator. Also the burden of that information that I withheld from my mom— So in effect, my mom was not aware of what was going on, so it impacted the delivery of care because of communication.

RC: Lorena, thank you for sharing that. I feel so identified with your story because many patients come to me, and they've been seen for several years, followed by many doctors. And basically the issue is that they come because they're following up for diabetes, and when you ask them, "Why are you coming?", they don't know. They say, "I have been coming to this doctor," they transferred that patient to me. And when I tell them that you know that you have diabetes, it's like no; and I tell them that you know that you're taking Metformin, for example, for diabetes. And they say, "No, I'm just taking the medication that my doctor prescribed."

And finally that day, that day that they sit down with me and then I talk to them in Spanish, they realize what they have been dealing with for the last five years. So really it's so important what you mentioned and how that affects a great part of what we call an immigrant community— and we're talking about the Latinx community.

[7:11-10:45] Dr. Bonilla Highlights her Advocacy Work

BV: And so Lorena, maybe you can tell us a little bit more about the work that you do, not only in your day job, but also outside of your clinical work.

LB: Sure. I am one of the co-founders for Doctors for Camp Closure, so I do a lot of advocacy in that organization, and it's very rewarding because I get to use my medical expertise, in terms of impact: in this case, more recently, the pandemic and holding people in detention during the pandemic in poorly ventilated areas in close spaces. And I've been able to advocate for them with other immigrant advocacy groups, so as a result of this work, we've actually had one successful outcome with one of the detention centers here in Florida, the Glades County Detention Center. The immigration in March released a press release saying that they were no longer going to have detainees in the Glades Detention Center.

So as of now, we have zero detainees in the center. And this has been a collaboration with a lot of organizations, and it just kind of shows you that our medical voice has an impact; that involvement is very enriching. I have had the opportunity to work with like-minded individuals who care about the humanitarian treatment of people.

And I think my role as an internist is not only treating patients individually, but looking at their environment and the social factors that impact their health. I would say that immigration itself can be treated as a social determinant of health; their immigration status determines in part what their health is gonna look like.

BV: I'm glad that you brought that up Lorena, because even in medical education, learning about the social determinants of health is something that I see now in curriculum, but wasn't necessarily a part of my medical education as much, I think, as it should have been. And there

are a lot of things that clinicians and physicians who are my age and older are learning; there's a learning curve. So why don't you talk a little bit about some of the things that you have learned through your work?

LB: Sure, and I think, you know, we all go into this profession because we have certain qualities of caring, doing a service for the patients, and curiosity. And I certainly love to learn about different cultures.

So when I have patients here in Miami (that's where I practice) I'll have patients from different socioeconomic backgrounds, and I have patients who have different occupational fields; some are working, you know, as part of the healthcare industry. There's a lot of foreign medical graduates that work in the healthcare industry, but we also have people who work in construction.

So I look at their life outside of them coming with an illness, and I put that into context. So I'll ask those questions, you know, “Are you a first generation Latino?”, “What kind of work do you do?” Because all of those factors will impact their health.

I would say ask questions, but have some education prior to going into asking those questions that you feel comfortable and that the patient is gonna feel like you care about them and you legitimately wanna work out a plan in conjunction with the patient.

[10:45-16:27] Suggestions on Best Practices in Immigrant Health

BV: I think that's such great advice, Lorena, thank you for that. And I think it highlights that we definitely need to be aware; we need to know what's going on around us, and what may be affecting the patients that we take care of. One thing that I'll highlight in just preparing for this discussion is that I was looking at some of the standards and suggestions on tackling migrant health, and the World Health Organization actually hosted a component of the United Nations General Assembly in 2017, and they discussed ways to improve healthcare delivery for migrants and refugees by focusing on patient-centered and intercultural approaches, which is in the interest of the host country. It's in all of our interests.

So they talked a lot about understanding the nature of the health needs of your patient and barriers that might exist. One that you just talked about was financial: so a patient can't afford Lantus, which is very expensive, so we might have to troubleshoot.

And just knowing that, right? What medications cost, what barriers there may be, is very helpful. And the other thing is they really talked about learning from success and failures and different approaches, so I think there's a lot to learn. You've highlighted some of that, and I hope that this discussion will prompt people to think a little bit more about the patients that they take care of and not just ask questions to ask questions, but to ask questions to help intervene and partner with the patient to improve their healthcare.

LB: So I had a 50 year old or so gentleman who worked in construction; he's a construction worker. And he came in with 72 hours of dizziness and left sided weakness. And during his workup, the sister was present in the room, providing the history. He didn't have a primary care doctor and he was diagnosed with an acute stroke. And I thought to myself, why did he wait 72 hours? And he's working in construction.

So I had to provide him education that it's very dangerous to be having symptoms of dizziness and weakness and getting up on a ladder where he could fall and injure himself. But this is very common. I find in patients who feel a need to go to work every day, and then they will go to the emergency room when they are unwell, and they push the limits of their illness to the point where it becomes more dangerous.

So he came in 72 hours, not as soon as the symptoms of the weakness showed up. So there was a delay in diagnosis, therefore, a delay in his care. And I see that kind of pretty much across the board.

RC: Lorena, so good that you mentioned this because something that also comes to my mind is how these patients, when they come to the country, that they don't understand the system. They don't have the education on where to go. And many of them go to the ER, when really there are sometimes some community clinics that help, but it's difficult to find it.

And a story that comes to my mind is patients during the COVID pandemic at the beginning. They didn't want to get tested because in all of these big centers where there were testing centers, there were police or ICE near those places. The reason unclear, of course, this is different from state to state, but the reason here in Arizona was unclear why ICE was in the centers.

So what we decided to do was that our community clinic that served mainly undocumented population, we started having the testing for us. So we asked for the county to provide us with the testing, and we were doing that in a place that was a little bit more safe for the patients. But I feel that this fear, to go to a place because they are thinking that something can happen; they are thinking that if they use resources of the state or the federal government can influence their status— somebody will know their status. It got to the point where they don't seek care until almost the end of the point, or you have the stroke, or you have the myocardial infarction, or you die at home with a heart attack because you were so fearful. And that's what I think that you mentioned, a great point is education. Education for this population, trying to make them aware that there are resources, that there are people that really care for them in the entire country, and make them aware it can change life or death for one of these immigrants.

BV: Yeah, and I would also like to highlight and remind our listeners that there are immigrants of all types, too; so not only are there refugees or those who are undocumented, but there are a lot of reasons why there are some people who are not from this country and may not understand the healthcare system.

If you can imagine, there are some people that come to the US who never have any preventative care, so they don't know that that's a thing, that you have a general practitioner that just checks up on you. In the work that I do in Nigeria, most people only go to a healthcare center if they're very, very sick. Lorena, just as you talked about, and there aren't those services. There's so much here in the US, and that communication, especially when they first arrive in the country, can make a big difference.

[16:27-18:57] Language Used Surrounding Immigrants

BV: I do want to talk a little bit about some of the language that's used surrounding immigrants in our country, because I think that there is different messaging that can affect not only the attitudes, but also perceptions of physicians. And so Lorena, maybe you can talk about what

you have seen or heard surrounding the work that you do, and how the language when describing immigrants has maybe affected either patient's care or some thoughts and ideas.

LB: So when Title 42 came about, it was under the Trump administration policy to not allow immigrants to come to the United States through the traditional asylum process. So it was used as a policy to prevent immigrants from using the asylum process to get into this country under the premise that we were in a pandemic.

Well, the CDC lifted this Title 42 and said we no longer need this because we have access to vaccines. And the media was handling the situation by portraying these immigrants as a tsunami, a wave is coming, and that is a negative connotation and stereotype of immigrants. So when physicians and other professionals in the healthcare field treat immigrant patients, they may have certain biases because this is what they're hearing in the media.

And so we have to kind of check ourselves, and realize that for the negative stereotypes that exist for immigrants, there's also positive ones that are just not being highlighted. For instance, all the medical graduates that are contributing to the healthcare field. They're immigrants. And here in Florida, at least 70% of the immigrant population is making contributions to south Florida, and we could say that for every state.

So we have a need, even for just having the food that we nourish our bodies with— farm workers; they're contributing because they're bringing these essential meals to our tables, right? In the industry of construction, so construction, agriculture, the science fields… You can find an immigrant in every single area. So this is something that needs to be balanced with the negative messaging that we're getting in the news.

[18:57-20:43] Categories That Influence Care: 3 C's

BV: Yeah, thank you so much. I do wanna highlight too, that there was a really great article that came out in 2019 that did a systematic literature review over challenges in healthcare delivery of migrants and refugees and high income countries, which the US is one of those.

And the paper went through and talked about several categories which influence healthcare delivery and they used a three C model. So they talked about communication, continuity of care, and confidence. So the communication we've already talked about, the different language barriers, being mindful of that and having appropriate translators as in your personal experience, right, Lorena? So not translating, through a child or another loved one, but using appropriate services.

And also continuity of care, meaning healthcare information sharing. So if someone goes to one clinic and then they are seeing in a hospital, that continuity of care, if we share information that would be in the patient's best interest. And then just confidence, meaning trust, developing trust and mutual respect with patients, just like you said, Lorena, right? Making sure the patients know that you care, and cultural sensitivity training can really help physicians understand the importance of family structure, religion, gender roles, which helps us to collaborate with patients to have the best healthcare outcome as possible, and really ensures that patients have autonomy and they are collaborating in the decision making.

So I think it's such an important point, and I think something that our listeners can remember those three C's, the communication, continuity of care, and confidence of a patient in you as the healthcare clinician.

[20:43-21:56] Importance of Understanding Culture in Patient Care

RC: I definitely echo what you're saying because just listening to you mentioning the three C's is something that many of the time we lack in our 15 or 20 minutes of time that we have with a patient, and that's another different issue, but we need to be more aware that this is happening.

And something that you mentioned last time was that definitely immigrants are not coming from a specific part, they are all around the world and understanding the culture of them is such an important part of the encounter with the patient.

We know, for example, that in certain cultures, the female, the woman, is the one that leads the house, so if something were to happen to them, then we would create some problems. And that culture is continuously coming with all the immigrants, so it's not just a language problem. And I don't know, Lorena, if you have experienced that more than language problem sometimes is not understanding the culture of that specific population and then having some barriers in trying to deliver a good message for the healthcare of the patient.

[21:56-23:29] Educating Ourselves as Physicians

RC: And I want to go to another topic. What about education? How we as a physician community educate ourselves so we can, one, understand our own bias, and second we can overcome our own bias to give better care for the patients?

So can you tell us some of your recommendations: how do you deal with this every day, and some of the recommendations to make us more aware of these kinds of things and educate ourselves?

LB: Sure, so if you are a resident in training, I would encourage you to ask your faculty to see if they can bring speakers that can offer webinars or talks or conferences geared towards immigrant health.

That's one avenue, so if you feel that that's lacking in your medical education, make a request for your GME to get that incorporated. In fact, I'm going to be giving a talk actually in October to a family medicine residency program about certain aspects of immigrant health.

So that's one avenue, and then for doctors who are already in practice, they can go into podcasts such as this one, which is one area where you could learn. And there's other resources; I believe the American Medical Association, they have a lot of work and equity and you can explore there.

BV: Thank you for those recommendations, we will definitely put a few of these links and suggestions in our show notes for our listeners.

[23:29-27:04] Dr. Bonilla's work with Doctors for Camp Closure

RC: In the introduction, we talk about how you are the co-founder of Doctors for Camp Closure. So you are in this as a volunteer, you're giving your time to this organization. Can you tell us more about the organization, what they do? How did you come up with this idea, and how is it working right now?

LB: Sure, so the national organization, it started in 2019, and then I joined the local Florida chapter in 2020. And basically they collaborate with different chapters from all over the United States, and they come up with ideas in terms of advocacy, which could include letter writing, campaigns, certain presentations at Washington D.C.

So fact, November of last year, we traveled to Washington D.C., and we had a two day activity where we had speakers, we had different organizations such as Welcome with Dignity and other interfaith organizations that provided speakers, and we talked about Title 42 and why it should end. And then we had letters with signatures that we delivered to congressional leaders explaining why Title 42 had to end. And so we did that type of advocacy.

And then locally, I do advocacy here with detention centers here in Florida. And the reason why I do it pro bono is because I derive a lot of pleasure from using my knowledge to change the treatment of immigrants and to try to achieve humanitarian treatment of immigrants.

I develop good relationships with other professionals that are not in the medical field. A lot of these are immigrant advocates, lawyers, attorneys from ACLU and other organizations. So I'm developing other skills by collaborating and seeing how all this network can affect change.

BV: Yeah, I think your story really highlights to our listeners that even though you're a physician first, we're always advocates for patients and people within our community even if they're new, if they're immigrants or refugees. And that we can use our skills as physicians and our voice is very important because we care, because we take the Hippocratic oath, and we can be trusted.

So I think it's really great that your story highlights that advocacy can go beyond just the clinic or the hospital, but help patients on a larger scale. Here on The DEI Shift, we are always telling stories, and just like we have our segment of “A Step in Your Shoes” to hear about our guest, to build cultural competency and humility, we also focus on empathy.

And so when we are thinking about what others are going through, in this case, immigrants, we really need to take a step back and think about them being a person of equal worth as everyone else, and what they're going through and how we would want to be treated and how we can advocate for them.

RC: Yes, I echo you. I think that you summarized this so well. I think that we are humans, and that the most important thing of medicine and providing care is that we are treating other humans.

[27:04-28:44] Take-Home Points & Closing

BV: Absolutely. So we have talked about a lot today. In summary, we've learned about Dr. Lorena Bonilla and her journey into medicine, the passion that she has to do the work that she does, including pro bono work as a physician and her work with Doctors for Camp Closure.

We've also discussed a lot about the learning curve that we all have. We are continuing to learn as physicians, but in this specific area, we've discussed opportunities for education and resources to learn more about healthcare and immigrant populations. We've talked about the three C’s: communication, continuity of care, and confidence, and again, really highlighting the importance of advocacy and some of the wonderful stories Lorrena has talked about of patients that she's encountered that has really caused her to want to move forward in this space and continue to work on behalf of these patients.

RC: So thank you so much for sharing your story. Thank you for attending this podcast today and to our listeners, remember that you can go to our website for the episode show notes and a lot of resources there and articles that we referenced today are also available there.

So you can follow us on Instagram and Twitter at @TheDEIShift and thank you for tuning in. Thank you so much for my amazing co-host; it's always a pleasure to share things with her and we hope you join us next time.

BV: Thank you, Lorena.

LB: Thank you!

[28:44-29:55] Outro

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