Abstract:
There has been a significant increase in the number of asylum-seekers entering the United States in recent years, including children and unaccompanied minors. Upon arrival to the country, these young patients may seek care in an emergency department for acute medical issues related to their journey or chronic conditions that were undiagnosed or inadequately treated in their country of origin. The purpose of this article is to familiarize emergency department clinicians with the common medical conditions seen in pediatric asylum-seekers and outline the ethical and legal issues that may arise when caring for this vulnerable patient population.

Keywords:
pediatric; asylum-seeker; immigration; refugee; unaccompanied child

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Emergency Care of Pediatric Asylum Seekers in the United States

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A 7-year-old girl arrives to the emergency department (ED) in the custody of Customs and Border Protection (CBP), hyperthermic and obtunded, having just entered the United States (US) hours earlier. A 16-year old boy presents to the ED via local paramedic service with a thoracolumbar spinal fracture, having fallen off the US-Mexico border wall. One week after coming to the US, a 17-year old girl presents with a local relative to an ED thousands of miles from her point of entry with oliguria and muscle cramping.

Although not a new topic, there has been a resurgence in the US national dialogue about the state of immigration; how we approach those seeking asylum in our country; and how best to process such applications in a fair, humane, and safe manner. Politics aside, there are a staggering number of children entering the US seeking asylum, and it is not uncommon for them to require immediate medical assistance upon entry. For those without acute medical issues on arrival, there are often other issues such as chronic infections and the psychological sequelae of the trauma they have endured. The cases at the start of this article are just 3 examples.

This article aims to educate emergency medicine (EM) clinicians about who pediatric asylum-seekers are, highlight the breadth and scope of their presentations to the ED, and discuss both pathophysiologic and psychosocial considerations for ED clinicians treating this population. By understanding the context these children come from and the common medical issues they

may present with, ED clinicians can optimize their medical and psychosocial approach.

BACKGROUND

The terms *asylum-seeker* and *refugee* are often used interchangeably, but it is important to define and differentiate them. People may seek asylum in the US if they have "suffered persecution, or fear they will suffer persecution due to race, religion, nationality, membership in a particular social group, or political opinion."[1] By definition, an asylum-seeker has not been granted official legal status prior to entering the US. They can request asylum either at the border or after they have entered the country. An unaccompanied alien child (UAC) is one who has no lawful immigration status in the US, is under 18 years old, and either has no parent or legal guardian in the US or a parent or guardian is not available to provide care and custody.[2] Such UACs frequently come to the US for the purposes of seeking asylum. The technical process of the asylum application is beyond the scope of this article.

Refugees, on the other hand, are people who have legal status as a refugee prior to entering the US based on similar persecution or fears of persecution as a person who is seeking asylum.[3] By definition, their entry into the US is always known and always with permanent legal status. Given the different psychological, legal, and logistical hurdles that are unique to asylum-seekers in the US, this article will only focus on the emergency care of this group.

In 2017, 26 568 people were granted asylum in the US (16 045 affirmatively, ie, applying for asylum at time of presentation to the US, and 10 523 defensively, or as part of removal proceedings). However, that same year, US Citizenship and Immigration Services received more than 258 000 applications for asylum, with more than 31 000 of those filed affirmatively from Central America's Northern Triangle (Honduras, El Salvador, and Guatemala). Over the 5-year period from 2012 to 2017, the number of affirmative applications from that region increased over 800%, with more than half of the applications filed by unaccompanied children. Notably, of individuals granted affirmative asylum in the 2017, 30% were 17 years old or younger and 50% were less than 25 years old. The top 10 countries from which individuals were granted asylum that year were China, El Salvador, Guatemala, Honduras, Egypt, Mexico, India, Syria, Venezuela, and Eritrea.[4] Given the large numbers of people who enter the US via the southern border, this article draws primarily on experience from that region of the country.

The health status of asylum-seeking children has garnered attention recently with news headlines about children separated from their families at the border and pediatric deaths related to unrecognized deteriorating health while in CBP custody.[5-7] Less publicized but also important are issues surrounding sleep deprivation while in detention, severe injuries incurred by children because of improperly designed detention facilities, and the long-lasting mental health effects of detention itself.[8] Potential changes in the Public Charge Rule (whereby a person is considered dependent on the government for subsistence) are also likely to negatively impact immigrant families, causing them to use fewer public benefits for which they are eligible—such as Medicaid, food stamps, and the Children's Health Insurance Program—for fear of deportation. The resultant decreased use of primary care services may lead to increased ED utilization.[9,10] Children seeking asylum may present to the ED at various stages along their path to asylum, for a variety of reasons, in variable custody, for both chronic and acute conditions.

PRESENTATION OF THE ASYLUM-SEEKING CHILD TO THE ED

Initial considerations for the approach to the asylum-seeking child depend on how, and with whom, they present. A child may present to the ED in CBP custody either directly from a port of entry if they were found in extremis, or in CBP custody from a detention center if ill. In both scenarios, they may present without an accompanying family member if they entered the country unaccompanied or if they are separated from a parent because of family separation policy effects. Alternatively, if the child is living in the community while awaiting asylum proceedings, he or she may present with a family member or with someone purported to be a family member.

Given these various presentations, as with all children presenting to medical care, it is critically important to assess whom the child is presenting with, their relationship to the child, and who maintains legal custody. Unfortunately, there are numerous reports of children being released from detention to "family members" or Department of Health and Human Services UAC "sponsors" who may then place the children in human trafficking situations.[11] If there is any concern or suspicion about who the guardian is or whether the child is safe, clinicians should involve social work or the child protection team immediately. Although the

approach to the trafficked child is outside the scope of this article, clinicians should be familiar with red flags raising suspicion that a child is being trafficked and how to speak with, examine, and ensure the safety of such a child. Readers are directed to the article of Becker and Bechtel on this topic.[12]

Other considerations for the initial approach to this child include ensuring use of an interpreter that the child and family can fully understand. Although this may seem obvious, it is not uncommon for providers to obtain a history directly from the CBP officer without any direct input from the child herself. Not only does this violate most hospitals' Patient Bill of Rights, this has also led to incorrect assessments and inappropriate or missed medical care. Unfortunate extreme examples include recent child deaths while in CBP custody where some family members spoke only indigenous languages and could neither understand nor communicate with CBP officials.[13] As such, access to a comprehensive telephone-based interpreter service is imperative given the numerous languages one may encounter when caring for this diverse population.

ACUTE MEDICAL ISSUES IN PEDIATRIC ASYLUM-SEEKERS

In addition to the traditional history of present illness and review of systems, important questions include the child's country of origin, countries passed through during transit, the duration and means by which they traveled to the US, and where they have been since entering the US. Although useful guidelines and toolkits exist for the initial medical evaluation of immigrant children, including refugees and asylum-seekers, these are meant primarily for the outpatient setting and will not be covered here.[14,15]

A study of adult border-crossers in 2 major teaching hospitals in southern Arizona found that the most common admission diagnoses to the surgical and medical intensive care units are trauma, rhabdomyolysis, acute liver injury, dehydration, acute kidney injury, and encephalopathy.[16] Of 55 patients, 13 required intubation and ventilation, 6 had severe sepsis, and 2 had septic shock. Notably, although this was an adult study, the median age was 27 years, and almost all were previously healthy, similar to a traditional pediatric cohort.

School-aged children and adolescents seeking asylum are also at risk for the above-mentioned illnesses and injuries, as these are directly related to environmental exposures. Children may have walked hundreds of miles prior to crossing over the US border, sometimes through hot and treacherous terrain without ready access to food and water. These conditions may lead to severe malnutrition, dehydration, and increased vulnerability to infection. One particular condition that has been well documented in asylum-seekers is "border-crossers' nephropathy," an exertional rhabdomyolysis compounded by acute kidney injury from dehydration.[17] Common complaints include weakness, generalized body ache, leg pain, and foot blisters. In a study of adults by Ossai et al, 12% of 42 patients with this condition necessitated hemodialysis. Although this condition is more likely to present in EDs closer to the southern border, there are case reports of border-crossers making it all the way across the country before presenting with significant rhabdomyolysis.[18]

With respect to physical trauma, those who attempt to cross into the southern US by climbing over the border wall may present with various orthopedic injuries given the significant height of the wall and the often uneven surface on which they land. One stretch of the wall separating Nogales, AZ, from Nogales, Mexico, is known as *ankle alley* given the number of fractures that occur in this area.[19] The most common fractures involve the thoracolumbar spine, calcaneus, ankle (rotational fractures), tibia (tibial pilon), and the pelvic ring.[20] Those who end up in child or family detention facilities are also at risk of trauma because many of these facilities are retrofitted prisons not meant for children. As such, there have been documented cases of finger injuries from spring-loaded doors and other trauma related to non–child-proofed areas.[21]

Female UACs attempting to cross the US-Mexico border are at risk of kidnapping and rape by gangs or smugglers encountered en route.[22,23] As such, screening for pregnancy is important because this may not come out in the history.

In addition to physical complaints and presentations, child asylum-seekers presenting to the ED are likely to have significant mental health needs. A recent survey of Central American asylum-seekers by Medecins San Frontieres found that more than 40% had a relative who died due to violence in the preceding 2 years. A similar percentage reported direct attacks or threats often in the context of gang violence. Almost 70% reported being victims of violence during their journey to the US, and almost one third of women had been sexually assaulted during transit.[24] Given this background of witnessing or experiencing violence, children seeking asylum often have significant mental health issues that may be exacerbated by the effects of detention and family separation on arrival.

Lastly, asylum-seeking children are at risk for common infections and flares of chronic conditions (either previously established or undiagnosed). They differ from their non–asylum-seeking counterparts, however, in that many of these children are detained with limited access to medical attention. When they first present to CBP custody, medications (such as inhalers or insulin) may be confiscated upon intake. It is unclear what their access to these medications is while in detention and how prescriptions are updated and refilled upon release from detention. Given the potential delay in accessing both general and specialty care, asylum-seeking children may present late in the course of their illness.

Table 1 outlines a nonexhaustive list of medical considerations when pediatric asylum-seekers present to an ED.

MEDICAL ETHICS AND DUAL LOYALTY CHALLENGES

Treating asylum-seeking children in an ED poses several difficult legal, logistical, and ethical challenges. In 2011, Immigration and Customs Enforcement and CBP issued a Sensitive Locations directive stating that hospitals are protected locations where "patient medical needs are paramount."[25,26] This directive has not been codified into law, and numerous instances of its violation—including in pediatric patients—exist. Such instances include CBP arriving to EDs, arresting patients whom they suspect have undocumented status, requesting sensitive patient health information, and restricting family members' access to the patient.[27,28] Such instances put clinicians in the difficult position of feeling a dual loyalty to care for the patient on one hand and to obey the orders of law enforcement on the other. Many hospitals now have policies that CBP may not enter patient care areas, or at least not until cleared by the hospital's security and legal teams. Given the amount of additional stress this places on the child and his guardians, the interference it causes in the delivery of care, and the ethically questionable nature of a law enforcement agency dictating aspects of a patient's care, it is important to know your hospital's policies around this issue.

How one documents a child's immigration status is another nuanced but important aspect of care. While social determinants of health are necessary to consider when evaluating a patient, the generally accepted wisdom is that more harm than good comes from documenting a patient's immigration status in the health record.[29] Although it is reasonable to expect that anything in the medical record would be HIPAA-protected, it is not clear if this legal medical privacy extends to undocumented minors, and there have been instances of the US government using protected health information as evidence against children in deportation hearings.[30] As such, a child's immigration status should be left vague in the records with only the minimum information necessary documented to ensure appropriate medical care. Despite this lack of specificity in the patient's medical record, it is conversely imperative to involve social work early in the visit to best provide access to various social, legal, housing, and other resources for the child and his family. If there are human trafficking or other safety concerns for the child, mandatory reporter laws still apply.

TABLE 1. Emergency medical considerations in pediatric asylum-seekers.

Acute kidney injury
Anxiety
Dehydration
Depression
Envenomation
Human trafficking
Hyperthermia
Infection
Physical trauma sustained during transit or while in detention
Posttraumatic stress disorder
Pregnancy
Rhabdomyolysis
Suicidality

SUMMARY

Recent US government policy proposals aim to improve medical triage procedures, medical training, and resources for CBP with the goal of improving recognition and care of illness in pediatric asylum-seekers.[31,32] If passed into law and implemented correctly, such policies would greatly improve the health of child asylum-seekers. Nevertheless, these children will continue to experience trauma in their home countries, leading them to seek asylum and possibly experience further violence and dangerous environmental exposures while en route to the US. It is therefore important for emergency department clinicians to be familiar with the unique exposures, complex legal status, language barriers, and other physical and

psychosocial stressors of this vulnerable population to provide the best possible care.

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