Part 1

Clinical pediatrics in the Mexican immigrant community

Insight into the impact of culture on the health of Mexican-American children.

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The US continues to be a country of immigrants. As of 2006, roughly 37.5 million immigrants (documented and undocumented) were living in the US, accounting for 12.5% of the total population. Of these, 30% were from Mexico.[1]

These new immigrant families bring with them their language, culture, and religious beliefs. And they also bring some health issues specific to the region from which they originated. As pediatricians, it is important to be aware of how these issues impact our clinical practice—whether it is in formulating a differential diagnosis, performing a physical examination, or communicating a diagnosis or treatment plan. Failure to do so can significantly impact the quality of health care received by these patients.

In Part 1 of this series, we will review alternative approaches to health care, popular medications, as well as nutritional beliefs found in Mexican culture. Although some of the cultural beliefs relating to health may be affected by educational level and socioeconomic status (SES), many of these practices and beliefs transcend SES.[3] It is important to note, however, that not all the beliefs and practices discussed in this article are followed by all Mexican-American families.

Editor's note: Statements regarding beliefs, practices, and behaviors without citations have been included when such beliefs, practices, and behaviors have been regularly noted by the author and her colleagues practicing at a community health center, where over 95% of patients and/or their families are Mexican-American immigrants.

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A different culture of care

In many countries, including Mexico, families are accustomed to going to pharmacies and legally purchasing medications such as antibiotics, steroids, narcotics, and birth control without prescriptions.[2] When these families come to the US, there is the perception that they will receive the same types of treatments, only to encounter more stringent regulations.[3] They may then seek out local "pharmacies" (botánicas or hierberias) that illegally sell medications brought from Mexico[4] (Figure 1).

When asked, families may share that they are giving their child penicillin, either orally or injected, by an untrained relative, folk healer (*cuarandero)*, or pharmacy owner.[4] Some parents may also have medications sent by relatives in Mexico. Examples of these medications include:

—Quadriderm–A topical cream containing betamethasone, gentamicin, and clotrimazole. Parents may use this cream to treat rashes (including facial rash) on their infants or older children.

—Metamizole (dipyrone or neo-melubrina)–A nonsteroidal anti-inflammatory drug (NSAID) available in Central and South America. This medication is not available in the US because of its association with agranulocytosis and aplastic anemia.[6] One study examining the use of metamizole by Spanish-speaking families in a pediatric clinic found that 35% of those screened admitted to giving metamizole to their children. Of these, 25% had purchased the medication in the US.[7] Parents from Mexico were also found to use metamizole more frequently than parents from other Spanish-speaking countries.[7]

Therefore, it is always important to ask families if they are giving any medications to their infants and older children, including drugs sent from Mexico or those purchased at *botánicas*.

There may also be variation in how these families use FDA-approved medications. Some parents, for example, may give their children approved acetaminophen or NSAIDs without knowing the proper dosage or frequency. This lack of understanding may be exacerbated by the fact that many over-the-counter medications have instructions written in English only (see Language barriers in primary care).

As an alternative, parents may turn to Mejoralito, a brand name of acetaminophen often used in Mexico. Mejoralito is available in a children's form (80 mg chewable tablets) and in an infant form equivalent to the infant drops sold in the US (80 mg/0.8 mL). It is essential that we clarify with families both the dosage and the frequency of acetaminophen or NSAIDs they are giving their children, to prevent overdosing.

Similarly, a number of these families may be unaware that the use of aspirin in infants and children 18 years and younger is contraindicated secondary to its associa-

Figure 1 **A *botánica* or *hierberia* is a store that may sell folk medicine, amulets, oils, incense, as well as medications.**[5]

IMAGE COURTESY OF DR. YOUNG

Language barriers in primary care

It has been shown that medical providers who treat patients with limited English proficiency often do not use professionally trained interpreters.[8] Either no interpreter is used, or untrained interpreters, such as relatives (including children under the age of 18 years), friends, hospital clerks, or other employees are used.

In one study of primary care physicians in California, untrained interpreters were used in over 50% of encounters, and no interpreter was used in 11% of cases.[9] Even providers who are fluent in Spanish may not correctly translate medical terms into Spanish, and may not be familiar with the idioms used in the particular region from which the family has emigrated.

Clearly, if communication is a barrier, this can easily lead to adverse outcomes, misdiagnosis, poor adherence to prescribed therapy and follow-up, and lack of continuity of care.[10] It is essential to use a professionally trained interpreter in all interactions with patients with limited English proficiency.

tion with Reye's syndrome. They may be more likely to give aspirin for pain and fever relief, or may give their children aspirin-containing medications, such as bismuth subsalicylate (in Kaopectate and Pepto-Bismol) or acetylsalicylic acid (in Alka-Seltzer).

Views on nutrition

With fast food and soda heavily advertised and readily available, it is often difficult for any parent to guide proper food choices and to set limits for their children. Immigrant families also face these issues.

In general, when families immigrate to the US, they often want to give their children "American food." Some believe that this includes the regular consumption of fast food, sodas, sports drinks, and other sugar-laden "juice" beverages.[11] In our practice within the Mexican immigrant community, we have observed infants being offered sugary drinks in bottles. Therefore, practitioners should consider inquiring about sugary drink consumption in early well-child visits.

Initiation and duration of breastfeeding in Latino immigrant populations vary considerably by degree of acculturation. In the Mexican immigrant population, with increasing years of residency in the US, there is a shorter duration of breastfeeding as well as less exclusive breast feeding.[12] It is unclear why this is the case; the cause is probably multi-factorial.

Given that most US-made powdered formulas come with instructions in English only, it is also important to address proper formula mixing to parents within this community as well. Water may also be given to newborns and young infants because of the perceived need for more liquid than breast milk or formula can offer. Therefore, practitioners should query parents whether they are supplementing with water, and if so, to assure them that breast milk or formula is all that the baby needs.

The importance of familismo

Immediate and extended family ties are very important to the Latino community—otherwise known as familismo. The mother, father, grandparents, aunts and uncles may come to their children's doctor visits, and all may have some say in how the child will be cared for. Grandmothers *(la abuela)*, in particular, often play a strong role in how their grandchildren are cared for, both in what they are fed as well what remedies are used.

The importance of the extended family in decision making, particularly when discussing serious medical conditions, must be kept in mind when caring for many Mexican-American families. Allowing for family meetings to include important extended-family members when discussing serious medical conditions is of utmost importance to ensure that medical decisions, treatments, and plans will be followed.[10]

In many Latin American countries, the degree of respect *(respeto)* paid to a physician may translate into the desire to not offend that physician. Some families may not want to question the doctor, even if they do not believe or do not understand some aspects of the diagnosis or plan. They may be used to a more paternalistic doctor-patient relationship.

It is important to be aware of this potential dynamic, and to attempt to provide a non-threatening open environment where families are encouraged and supported to ask questions. Latino families also expect to be shown respect by their physicians, in the form of a handshake both at the beginning and end of a visit, a greeting (eg, *buenos dias* [good morning], *buenas tardes* [good afternoon]) as well as being addressed in the more formal "you" *(usted)* as well as *Señor* (Mr.) or *Señora* (Mrs.).[10]

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Similarly, some mothers seem concerned that their newborns are not satisfied with only breast milk (*no se llena* [she/he does not fill up]) and feel obligated to excessively supplement with formula. One study looked at reasons why Latina mothers decided to supplement with formula, or not breastfeed at all.[13] Some who supplemented with formula believed that they were providing their infants with the benefits of breast milk as well as the "extra" vitamins offered in formula. Others were embarrassed by having to expose their breasts in public.[13]

The cultural belief of *susto* may also contribute to a Mexican/Latina mother's decision not to breastfeed. Followers of *susto* believe that if a frightening or emotionally disturbing event is witnessed, for example, by a breastfeeding mother, this event taints the mother's milk supply. As such, the mother would need to abstain from breastfeeding her baby for a given period of time until the fright has passed, so as not to pass on the tainted milk.

Some mothers also believe that if they are sick with an illness, such as an upper respiratory infection, they need to stop breastfeeding so as not to pass the infection to their infant.[14] If these perceived needs to not offer breast milk exceed more than several days, milk production will diminish. At minimum, Latina mothers should be provided with extensive lactation support, education, and breast pumps. This way, if they are able to breast feed, they might be more successful.

Initiating solids in infants may also occur earlier than recommended within this population.[15] Some families start by giving "tastes" of foods to their child as early as 2 to 3 months of age, while others are given soups (*sopas* or *caldos*), broth mixed with cooked vegetables and/or meat. Yet another portion are fed pre-made instant soups (*sopa huevona*—"lazy soup"). It is important to discuss infant nutrition with parents, and ensure that they offer a variety of soft vegetables, fruits, and meats without extra ingredients.

Lastly, the continued obesity epidemic of our youth, and the increased prevalence of type 2 diabetes in the Latino community,[16] makes it imperative for clinicians to address dietary issues on a regular basis. Interestingly, studies have shown that the longer Mexican-American immigrant children live in the US, the more likely they are to be obese.[17] ❐

Look for Part 2 , on infectious diseases and folk illnesses and remedies, in the March 2009 issue of Contemporary Pediatrics.

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