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NEW PERSPECTIVES

Caring for Refugee Patients: An Exceptional Education

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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 content 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 importance of taking the time to confirm the understand-

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ing 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 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 Spanish) as well as telephonic language services. In addition, we have an on-site dispensing pharmacy, clinical pharmacist, integrated mental health providers, dieticians, 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,

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Table 1. Overview of Education in Refugee Health
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

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 preclinic 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.

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