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

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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 hypertensio—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 Pakistan 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 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 ulti-

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mately 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 refused 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 diversity, 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.

References

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