

Can Academic Medicine Lead the Way in the Refugee Crisis?

Amir A. Afkhami, MD, PhD, MPhil, MA, MA

Abstract

The world is currently in the midst of the largest refugee crisis since World War II, with the highest interval of mass displacement in recorded history according to the United Nations. The United States has pledged to maintain its position as one of the world's top resettlement countries in response to this crisis. These new immigrants will arrive with exceptional chronic and acute medical needs, including higher

rates of behavioral health disorders. The author describes the health care challenges experienced by refugees seeking asylum in the United States and outlines the ways in which our health care system is currently deficient in helping refugee patients to overcome these challenges. He argues that the academic medical community can change this dynamic by standardizing and expanding instruction in cross-

cultural competence and behavioral health screenings throughout the spectrum of medical education. Ensuring the long-term well-being of refugees in the United States, including meeting their mental health needs, will be the best inoculation against the risks of violent extremism which so many fear. With the absence of national leadership on this issue, academic medicine can and should lead the way.

Editor's Note: This New Conversations contribution is part of the journal's ongoing conversation on global health professions education—how ideas, experiences, approaches, and even resources can be shared across borders and across cultures to advance health professions education around the globe.

The world is currently in the midst of the largest refugee crisis since World War II, with the highest interval of mass displacement in recorded history according to the United Nations (UN). In 2014, an unprecedented 60 million people were dislocated by armed conflict and instability—nearly twice the number from a decade earlier—and the UN predicts that this trend will continue for the foreseeable future.¹ The majority

of current asylum seekers come from Muslim countries, including Syria, whose civil war beginning in 2011 has been the principal accelerant for the current global upsurge in the number of refugees. The United States has pledged to maintain its position as one of the world's top resettlement countries by increasing the number of refugees it accepts every year from 70,000 in 2015, to 100,000 by 2017. This includes granting asylum to 10,000 of the over four million displaced Syrians in the next year alone.² These new refugees will arrive with exceptional chronic and acute medical needs, including higher rates of behavioral health disorders, often neglected because of a lack of access to appropriate health care prior to their resettlement.

The access to health care for refugees in the United States has vastly increased since the implementation of the Affordable Care Act. Upon arrival, refugees can purchase health insurance in the health exchanges and have the same protections and benefits in the insurance marketplace as citizens, including premium and cost-sharing tax credits. Refugees younger than 65 with incomes under 133% of the poverty level and limited assets are eligible for Medicaid; those who do not qualify can receive comparable benefits in the Refugee Medical Assistance program for the first eight months of their residence in the United States. Refugee children can similarly be eligible for the Children's Health Insurance Program (CHIP), irrespective of their country of origin.

Despite these benefits, many refugees will fall through the cracks of our health care system because of shortfalls in how the U.S. medical system is currently prepared to provide care to these individuals. Untreated behavioral health disorders, prevalent among refugees,³ will make it more difficult to seek help and navigate the critical maze of social services following resettlement. Refugees with behavioral health disorders will also have poorer prognoses and will face a range of other acute and chronic comorbid nonpsychiatric illnesses, which will profoundly impair their ability to adapt to their new surroundings. The White House has largely ignored this domestic challenge in its call to action on the global refugee crisis. By all accounts, the president's summit on the issue at the next UN General Assembly meeting in New York will largely sidestep the health care challenges facing host countries, including the United States. The academic medical community, however, is in a unique position to change this dynamic over the long term by standardizing and expanding instruction in cross-cultural competence and behavioral health screenings throughout the spectrum of medical education.

The Mental Health Needs of a Traumatized Population

The current wave of refugees from the Middle East have suffered through armed conflict, communal violence, and rape in unprecedented numbers. They will carry the emotional sequelae of these

Please see the end of this article for information about the author.

Correspondence should be addressed to Amir A. Afkhami, George Washington University School of Medicine and Health Sciences, 2120 L St. NW, Suite 600, Washington, DC 20037; e-mail: amiafk@gwu.edu; Twitter: @psych_doc.

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Acad Med. 2016;91:1595–1597.
First published online October 18, 2016
doi: 10.1097/ACM.0000000000001427

experiences, including a higher burden of mental illness. A systematic review of studies on the adult refugee population in the West showed posttraumatic stress disorder (PTSD) and major depressive disorder occurring at 9% and 5%, respectively, with high rates of comorbidity between the two.⁴ The rate of mental illness among Syrian refugees is even starker, with almost half reported to suffer from PTSD.⁵ Despite these data, mental health screenings for refugees prior to resettlement in the United States are mostly limited to detecting maladaptive behaviors, such as substance abuse and aggression, which have little relevance to the population of persecuted asylum seekers predominantly from the Middle East. During these screenings, psychological symptoms are often overlooked in favor of identifying and treating physical injuries and infectious diseases. Major psychiatric conditions are seldom diagnosed, and provisions treating them are not in place upon resettlement.

The federal government mandates a more comprehensive medical exam of refugees within 30 days of their arrival in the United States. However, the scope and organization of this assessment vary among states. Refugee health coordinators in most states do not elicit psychiatric symptoms that can result from exposure to armed conflict or torture, and those who do rely mainly on informal conversation rather than standardized questions and measures of distress.⁶

Cultural barriers and stigma also hamper diagnosis and treatment. Primary care providers, frequently the first point of contact for refugees in the U.S. health care system, often miss signs of depression and trauma, which can be camouflaged by culture-specific expressions of distress and social mores, which the providers do not understand. They also erroneously judge normal variations in behavior, belief, or experience that are particular to a refugee's background as psychopathology. Caregivers are particularly ill equipped to treat the growing numbers of asylum seekers from Syria and other Islamic countries. A recent poll indicated that over half of Americans have an unfavorable view of Muslims.⁷ It is unlikely that physicians are immune to broader societal prejudices and assumptions, which they must surmount to form the comfort, rapport,

and empathy necessary for proper diagnosis and treatment.

What Can Be Done

Breaking down the health care barriers faced by refugees should begin by improving the cultural competence of U.S. physicians who typically enter the workforce inadequately prepared to navigate the verbal semantics and varied communication styles of non-Western patients. Currently, training in culturally informed care continues to lag behind preparedness in other clinical and technical areas, particularly in graduate medical education.⁸ The Accreditation Council for Graduate Medical Education program requirements for cultural competency continue to be highly variable and inconsistent across specialties.⁹ New curriculum standards established by the Liaison Committee on Medical Education and the Tool for Assessing Cultural Competence Training, developed by the Association of American Medical Colleges, have improved the situation in undergraduate medical education. However, shortfalls and omissions persist in teaching medical students to respond to patients' diverse histories, faith, traditions, and value systems. Cross-cultural behavioral health, in particular, continues to be absent from most medical school curricula.

Preparing future physicians to be sensitive to the social and cultural dimensions of trauma and distress should begin at the foundational level by requiring incoming medical students to have a strong footing in the liberal arts. The current trend in undergraduate education away from majoring in the humanities has largely shifted humanistic education, central to developing multicultural sensitivity, to medical schools, whose dense curricula leave little room for nonclinical didactic training. Medical schools should instead focus on adopting a standardized and longitudinal approach to teaching cross-cultural competence, including necessary listening and communication skills. Similarly, residency programs should evaluate trainees for cultural sensitivity as part of their broader clinical skills and milestone measures. Role models and mentors with expertise in culturally informed care will be essential to providing the necessary supervision, challenging institutions to expand their faculty recruitment efforts to more

closely reflect the immigrant patient demographics.

The use of standardized evaluations for behavioral health can also help. A number of screening tools, such as the Harvard Trauma Questionnaire¹⁰ and the Beck Depression Inventory,¹¹ have been adapted to varied cultures and shown to have validity in assessing refugee populations. Yet, these screening tools continue to be an afterthought in both undergraduate and graduate medical curricula. Evidence-based screening tools should be incorporated into the curriculum at all levels, including at the continuing medical education level, where their use can be conveyed through state and institutionally based continuing medical education requirements, with immediate results.

The current national debate about refugees has largely focused on the security risks of accepting increasing numbers of Muslim asylum seekers. This has distracted the country from the more tangible social and moral implication of not meeting the health care needs of these new immigrants. Ironically, ensuring the long-term well-being of refugees in the United States, including meeting their behavioral health needs, will be the best inoculation against the risks of violent extremism which so many fear.¹² With the absence of national leadership on this issue, academic medicine can and should lead the way.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

A.A. Afkhami is associate professor of psychiatry, Department of Psychiatry and Behavioral Sciences, George Washington School of Medicine and Health Sciences, and associate professor of global health, Department of Global Health, Milken Institute School of Public Health, Washington, DC.

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Cover Art

Artist's Statement: Reflection

The painting on the cover of this issue is inspired by one of my favorite quotes by the philosopher Søren Kierkegaard,¹ who wrote, “To help somebody, first of all you must find him where he is and start there. This is the secret of caring.” I find that this advice can be applied to the medical provider–patient relationship; in understanding where an individual patient is, one can provide more effective care for the individual.

Being in the hospital can be a difficult and painful experience for patients and their families. The hospital is not only a physical structure and an organization in which the medical staff work, but, for patients, it is also a place of hope, fear, and uncertainty. Patients do not just see the objective information concerning their medical condition and its evolution, nor do they just see the protocol that might be established for the treatment of a specific disease process. They have their own unique stories and feelings of being ill and of being in the hospital, which are often stronger and more complex than what can be expressed in words.



Reflection

Sometimes it can be difficult to put ourselves in others' shoes so that we can feel and understand what they are experiencing. Yet, as empathy emerges, we can develop a more authentic relationship with our patients. This form of perceiving offers a unique understanding of a patient's health care outside the technical knowledge that we learn through our readings and our class lectures. Recognizing and valuing the experience of patients allows us to assign meanings to the hospital environment

from the perspective of unfamiliarity with the technical medical setting.

As I become more involved in patient care through my clerkships, I find that patients and their families are grateful for little actions and words. Sometimes these are events that are not typed into the electronic medical record or announced during patient rounds. They could range from providing warm blankets to patients to explaining when, where, and why lab tests and procedures are being performed. While these activities may seem simple in nature, they can create moments that have a significant impact on the patient–provider relationship and the patient experience in the hospital.

Edina Wang

E. Wang is a fourth-year medical student, Wake Forest School of Medicine, Winston Salem, North Carolina; e-mail: ewang@wakehealth.edu.

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