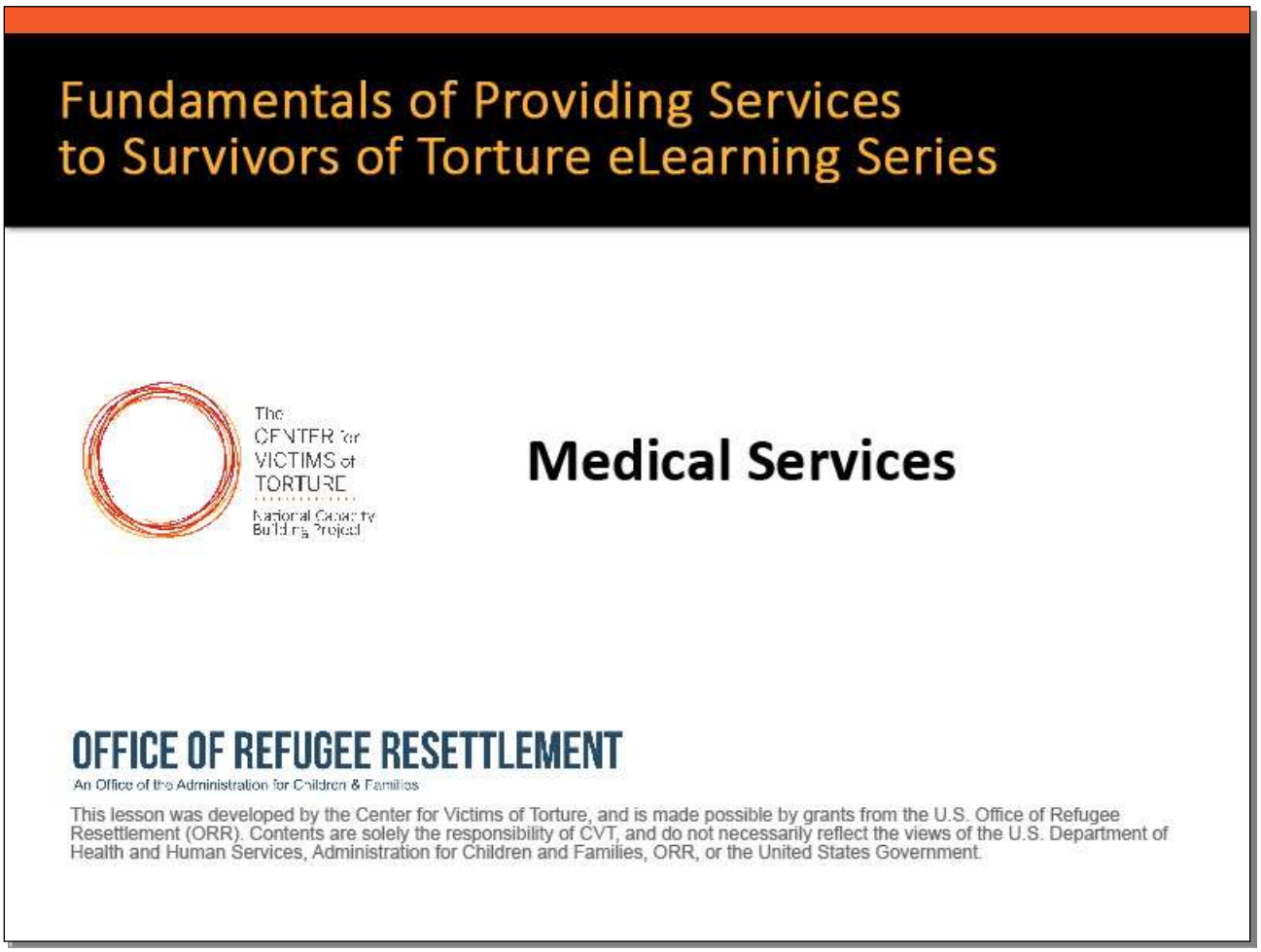
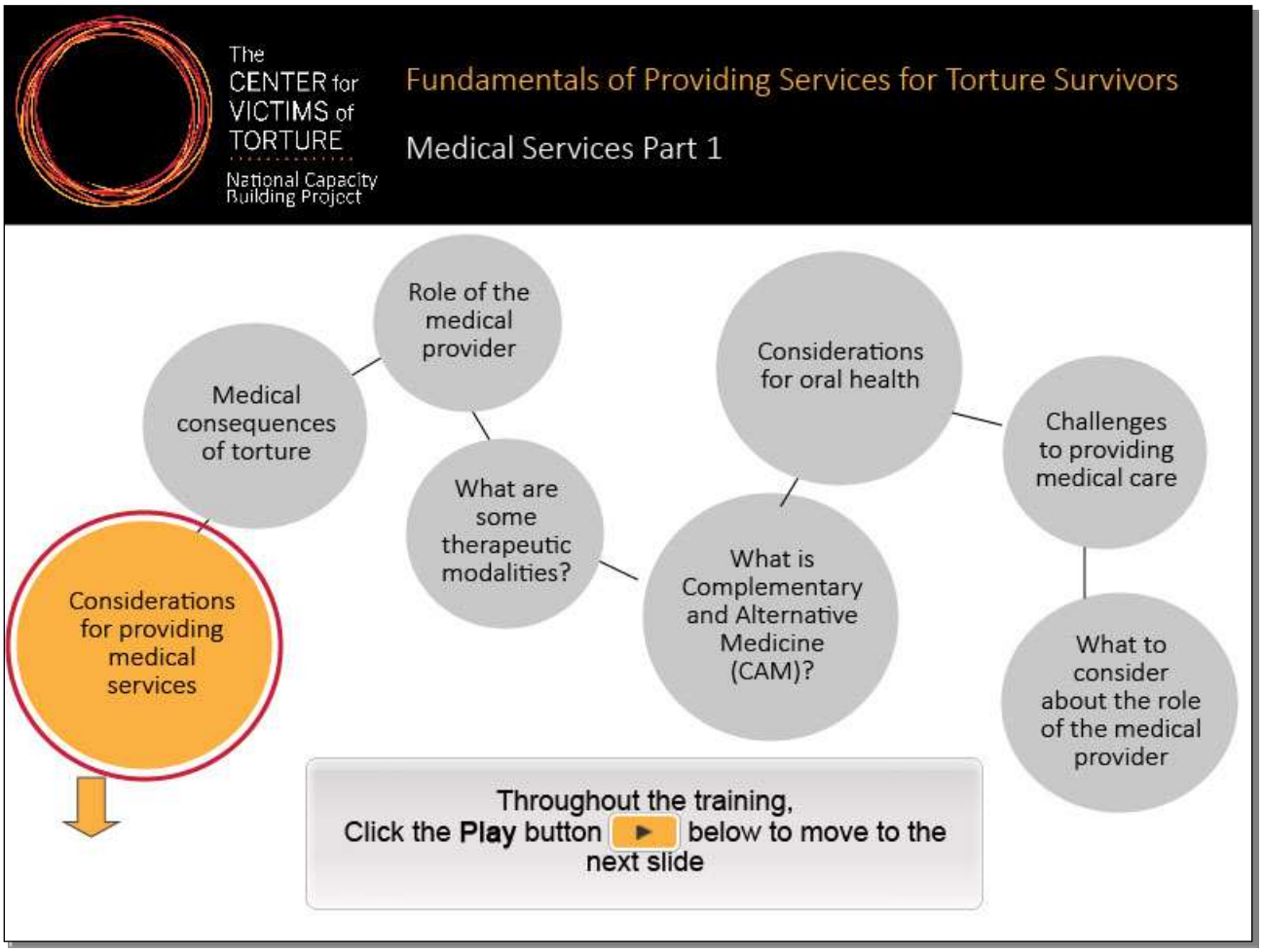
Medical Services Part One

Slide 1 – Welcome



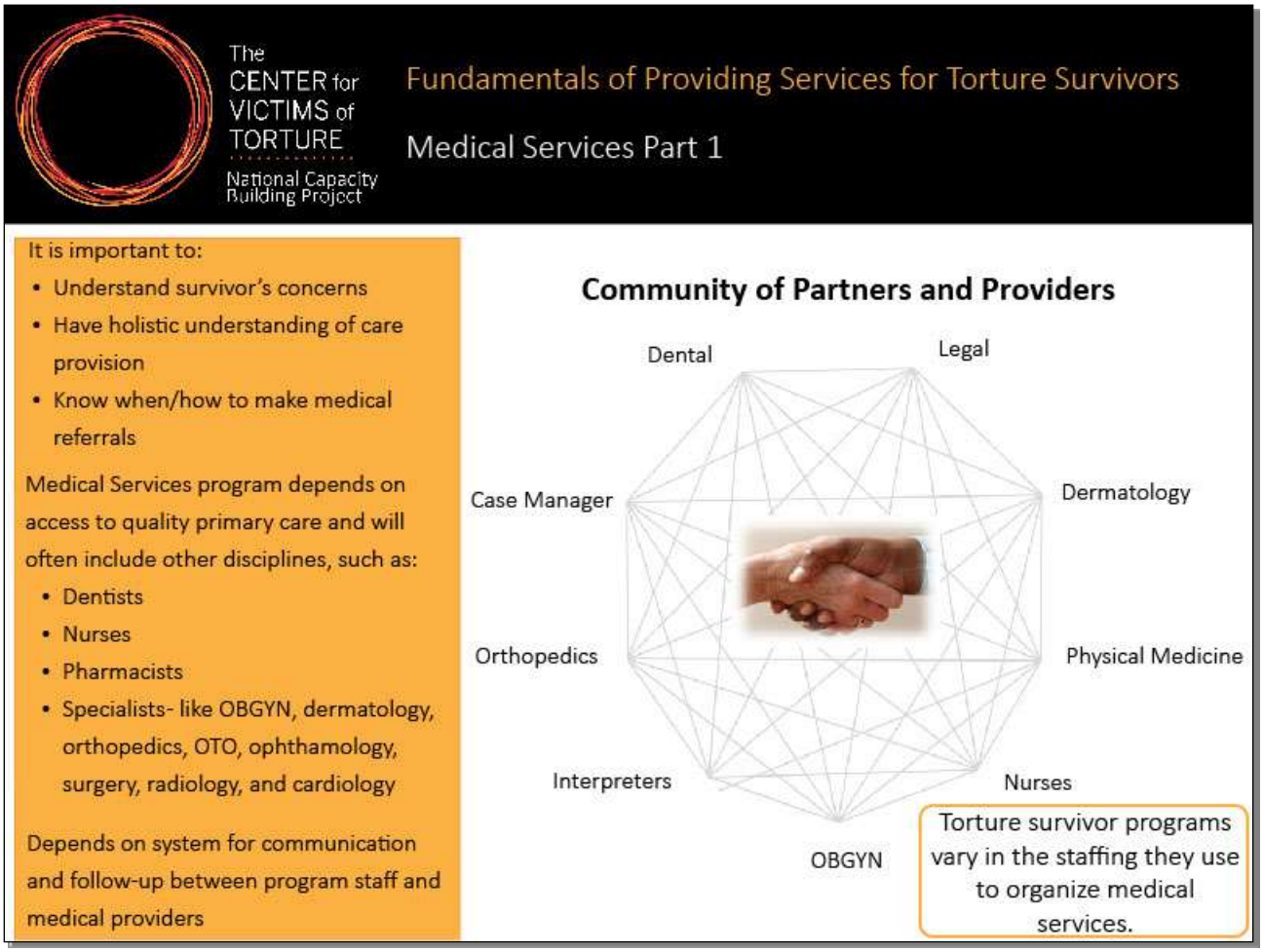
Welcome to the Medical Services unit in the Fundamentals for Providing Services to Survivors of Torture eLearning Series.

Slide 2 – Lesson Objectives



Hello, my name is Sondra Crosby. I am a physician, a general internist who has been caring for survivors of torture for 10 years. I will be presenting the lesson on caring for the medical needs of survivors of torture. Providing primary medical services to torture survivors requires dedication, a willingness to go above and beyond usual practice, a sensitivity to cross cultural medicine, and a solid understanding of the effects of trauma. In return, there are incredible personal rewards to caring for this population. While this lesson focuses on medical services, you'll see that the special considerations related to attitude and approach I present apply equally well to providers from other disciplines and service areas.

Slide 3 – Community



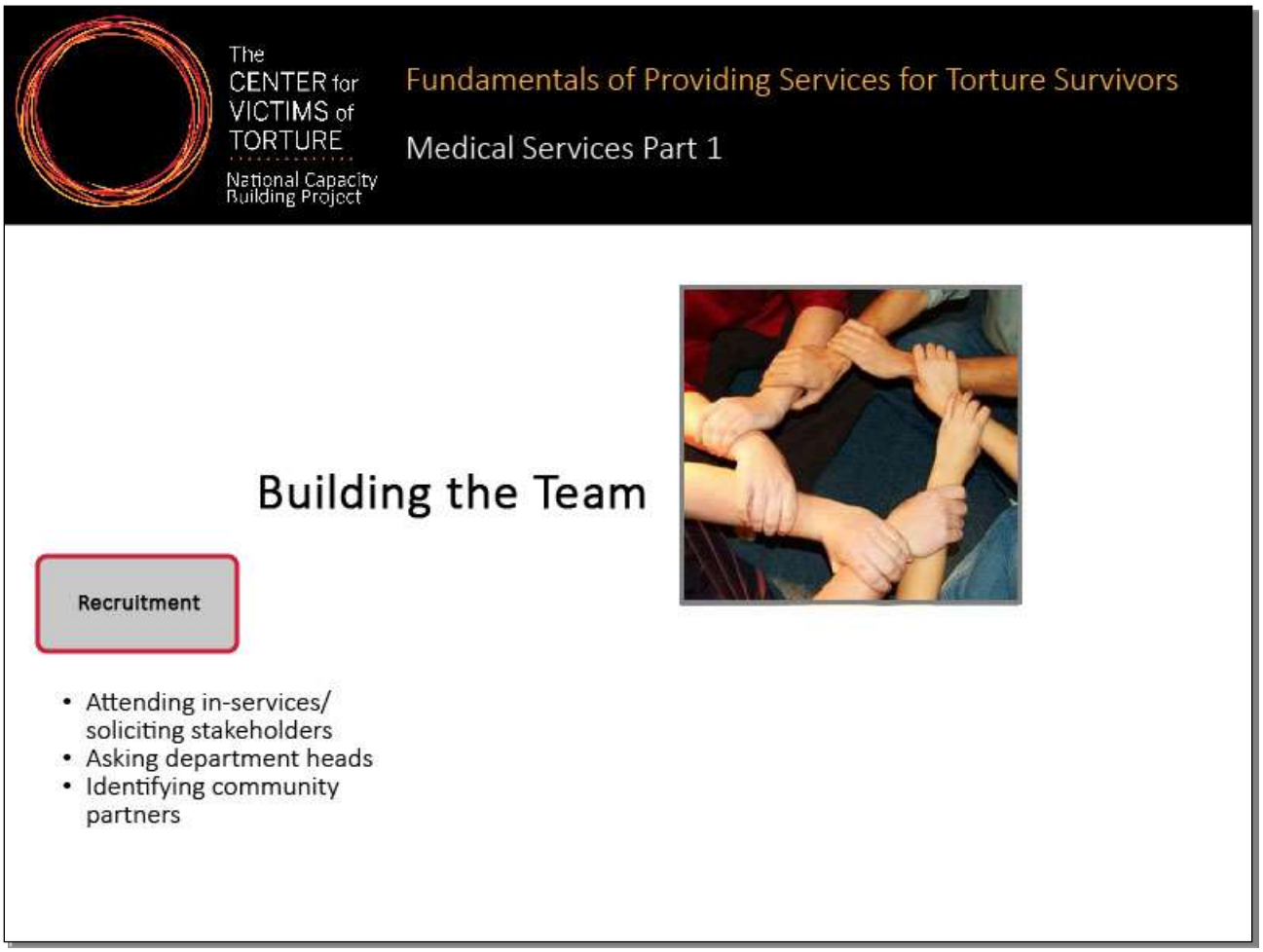
As you've learned, caring for survivors requires a multidisciplinary team approach, with the core team members including medicine, social work, case management, mental health, interpreters, and legal experts. Let me say at the outset, that while I am a physician working in a torture survivor program, I know that many programs do not have physicians on staff and that torture survivor programs vary in the staffing they use to organize medical services. Some have physicians on staff, others have nurses or medical case managers; others depend on social service or case management staff to refer to clinics or professionals in the community. While some of the material presented here is most directly relevant to physicians or other licensed medical practitioners, it is important for non-medical providers to be aware of the physical health issues that survivors may experience. This helps in several ways - being aware of and sensitive to all of a survivor's concerns, maintaining a holistic understanding of care provision, and knowing when and how to make a referral for medical assessment or treatment. To provide holistic care, it's essential for torture survivor programs to know where and how their survivor clients can access primary care medical services.

Whatever the staffing model, a medical services program depends on access to quality primary care, and will often include other disciplines such as dentists, nurses, and pharmacists, as well as medical specialists, like OB GYN, dermatology, orthopedics, otolaryngologist, ophthalmology, surgery, radiology, and cardiology. And it

also depends on a carefully developed system for communication and follow-up between program staff and medical providers.

To accomplish all this, forming alliances with community partners is essential. They may be instrumental in trust building with the medical system and may also assist with health education - for example, the importance of preventative care and HIV screening.

Slide 4 – Building the Team: Recruitment

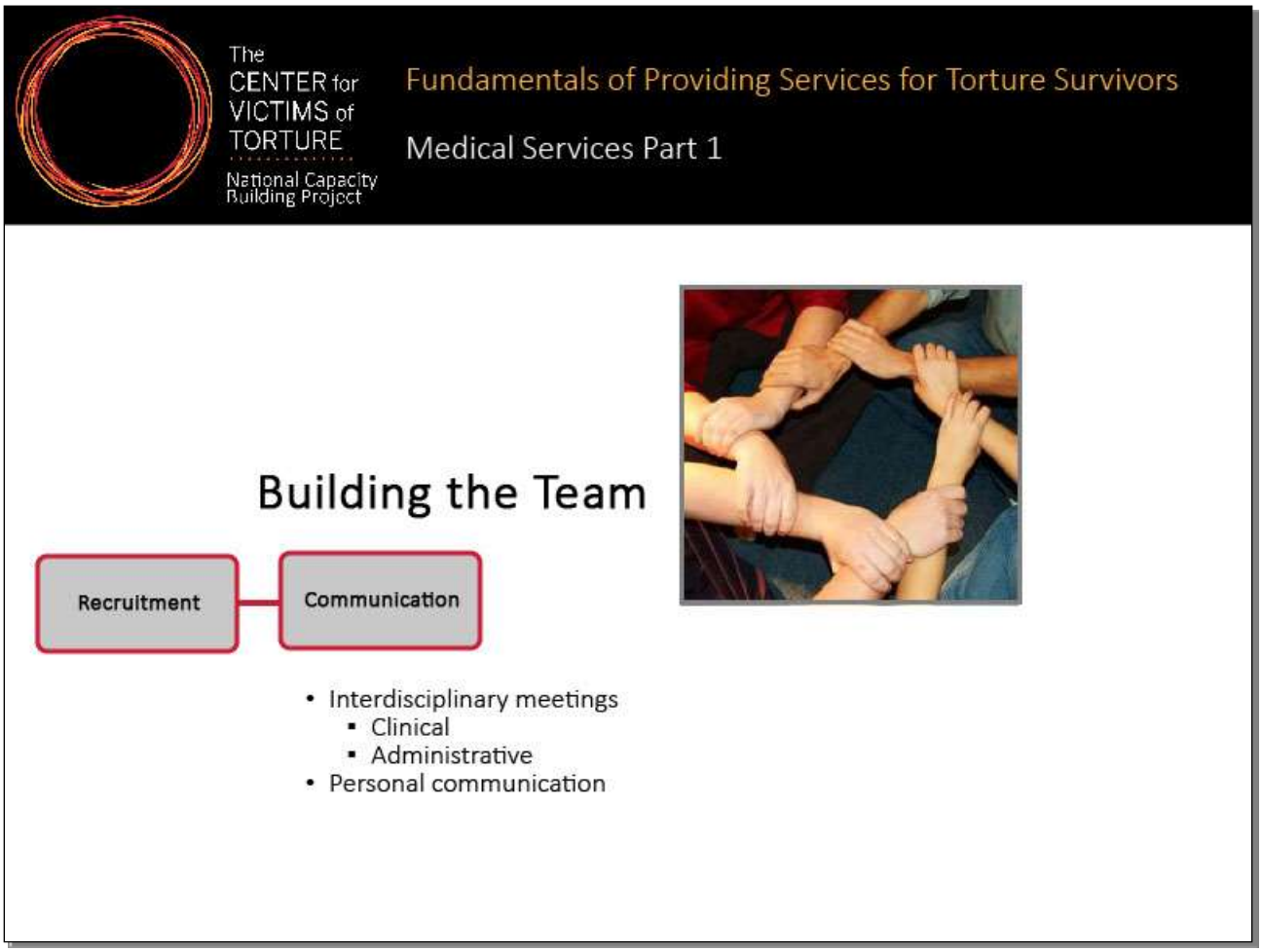


To create this community of partners and providers, it's important to build a cohesive, caring team. The way I've built my team is to seek out professionals with needed expertise, or those who have a particular interest and motivation to care for torture survivors. Then I help them develop the specialized skills and sensitivity to do the work effectively.

I've identified these individuals by attending in-services to departments or soliciting key stakeholders, or meeting with heads of medical departments at hospitals or local medical practices, volunteering to lecture to their staff, and asking for volunteers. I've also identified and contacted community organizations and individuals who have become critical partners in the helping survivors overcome barriers to care (cultural brokerage, peer educators, communities of faith promoting HIV testing and safe sexual practices). These community partners are often crucial in developing trust.

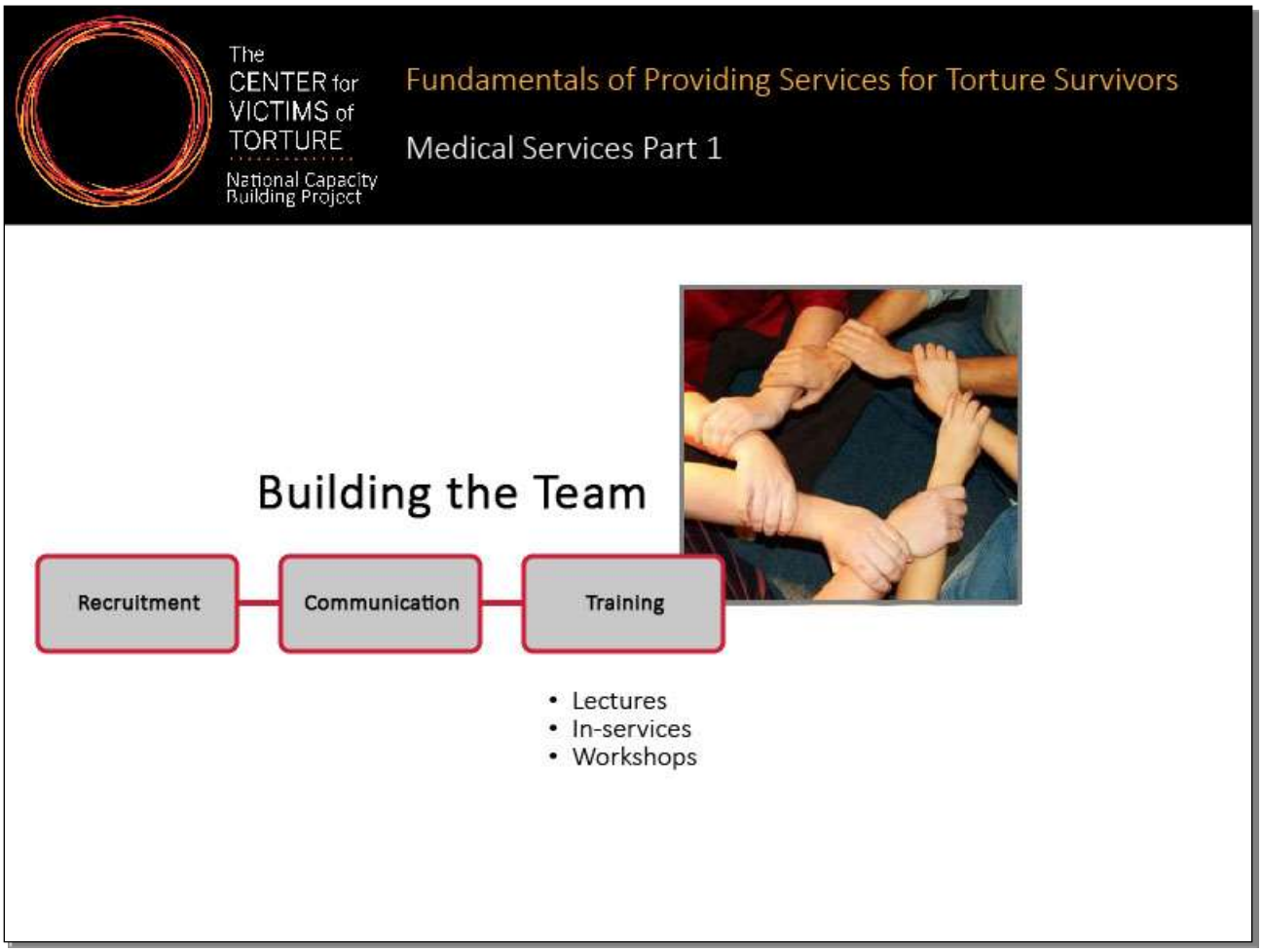
One example was utilizing the Somali Development Center as a site to meet with women and discuss hypertension, diabetes, depression and mental health, and other women's health issues. Another example was organizing an HIV counseling and testing site at a Ugandan celebration, dinner and dance to promote not only HIV testing, but engagement with medical services.

Slide 5 - - Communication



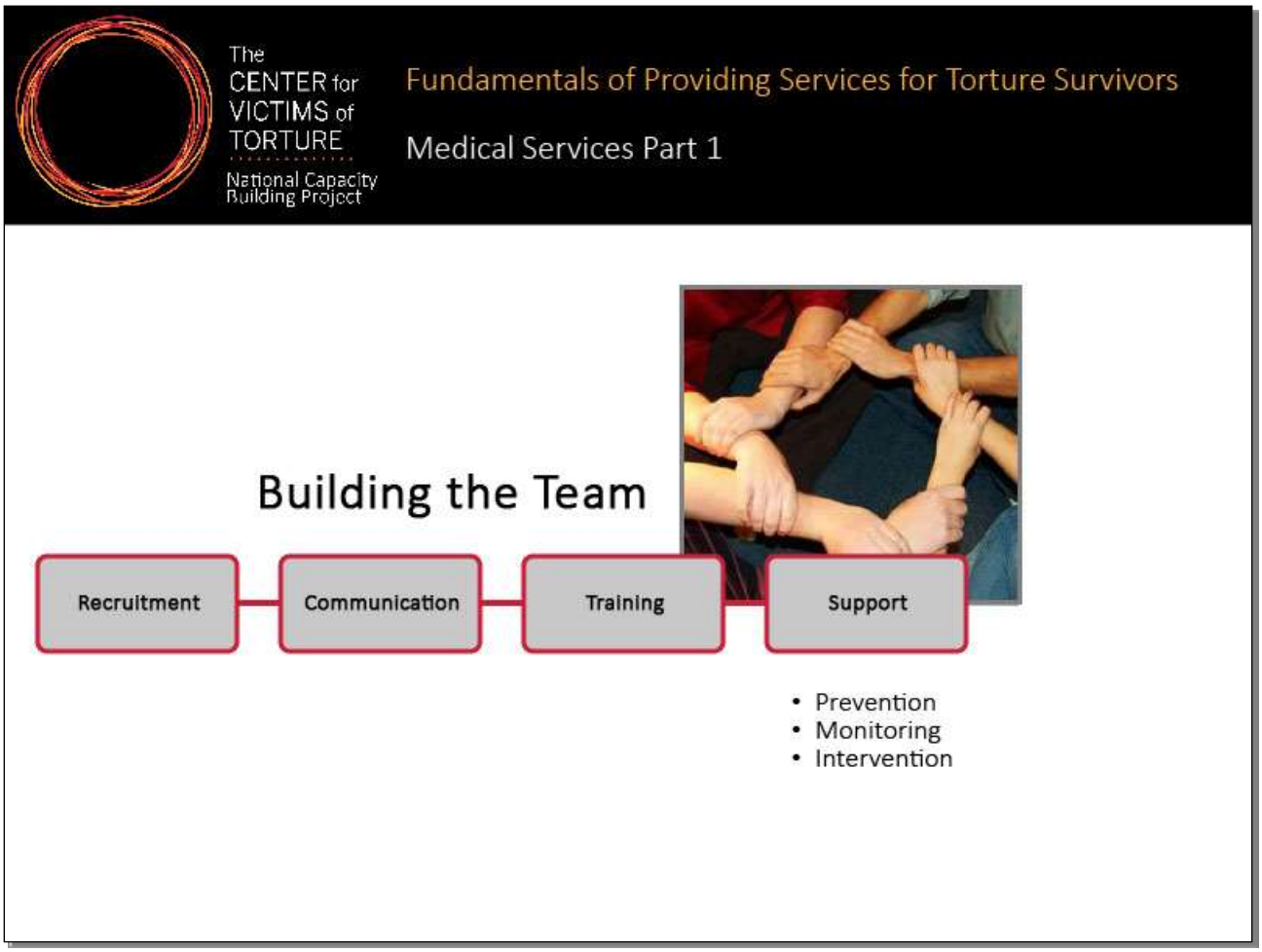
After building the team, it must be supported on an ongoing basis. Communication is important and can be challenging when providers span multiple disciplines and more often than not, are at different physical sites. This can be accomplished through regular clinical meetings where all aspects of a patient's care are discussed and treatment plans developed. Practically, not all members can attend meetings, so important information should be disseminated through minutes. Meetings can be supplemented by email/phone/or electronic medical record whenever needed.

Slide 6 - - Training



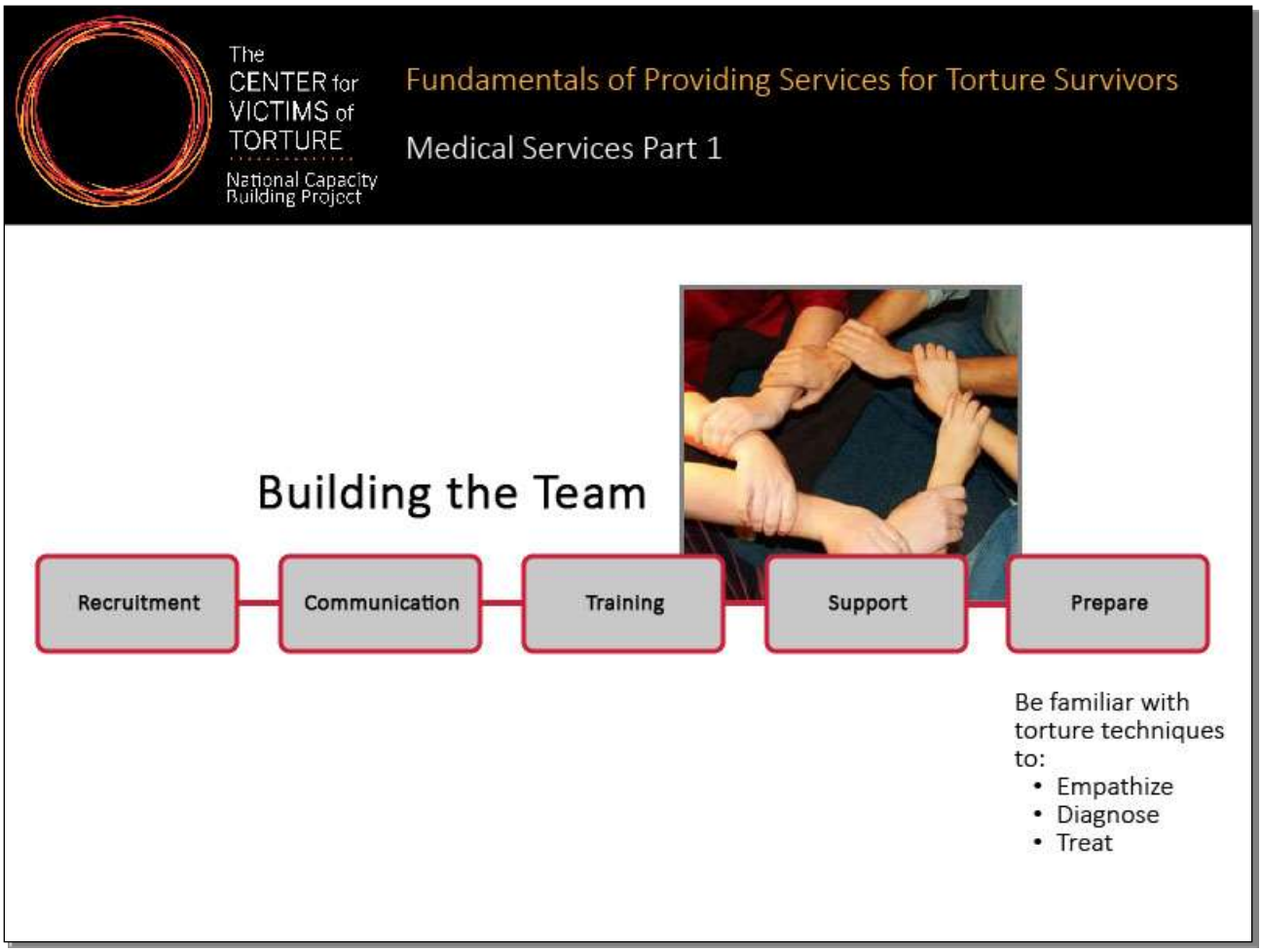
Another key support is access to ongoing training in the form of lectures, in-services, or workshops on specialized topics relating to medical care of torture survivors, and new developments in the field.

Slide 7 - - Support



Another key aspect of building a team is ensuring that there is a mechanism of support for all team members. Together with mental health team members, support services should be implemented for prevention, monitoring and intervention for vicarious trauma. Busy clinical schedules with little emphasis on self-help in primary care and medical subspecialties make this a particular concern.

Slide 8 - - Prepare

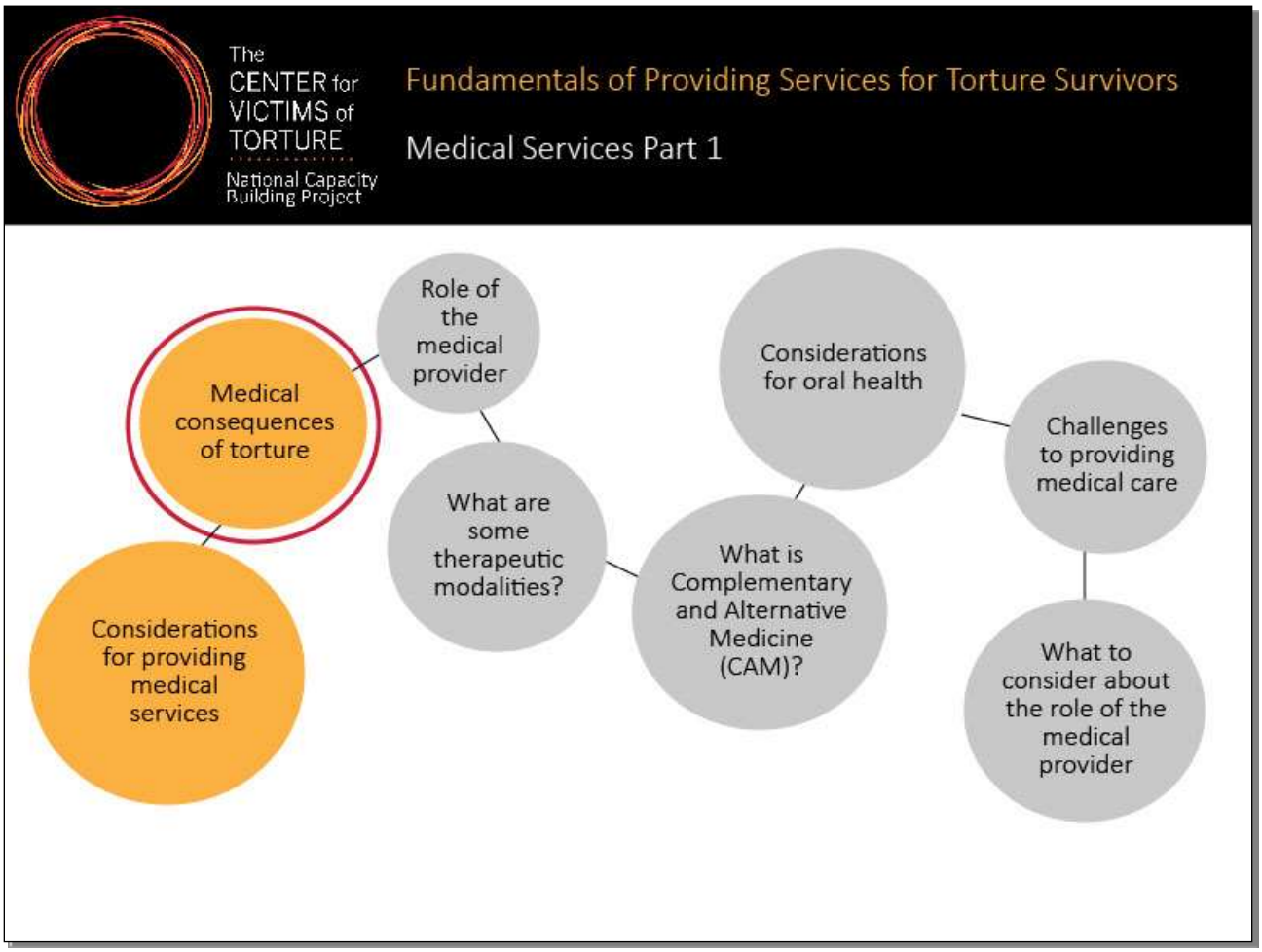


Finally, health professionals and others caring for survivors of torture should be prepared to hear experiences that can be very disturbing to the listener. It is important for health professionals to be familiar with torture techniques so they will be able to engage empathetically with the survivor. Survivors may sense that their difficult revelations are “too much” for the provider, and attempt to protect them. In addition, it is important for health professionals to be familiar with the mechanisms of torture in order to diagnose and treat potential physical consequences of torture, to alleviate suffering, and assist with the recovery process.

Slide 9 – Reflection

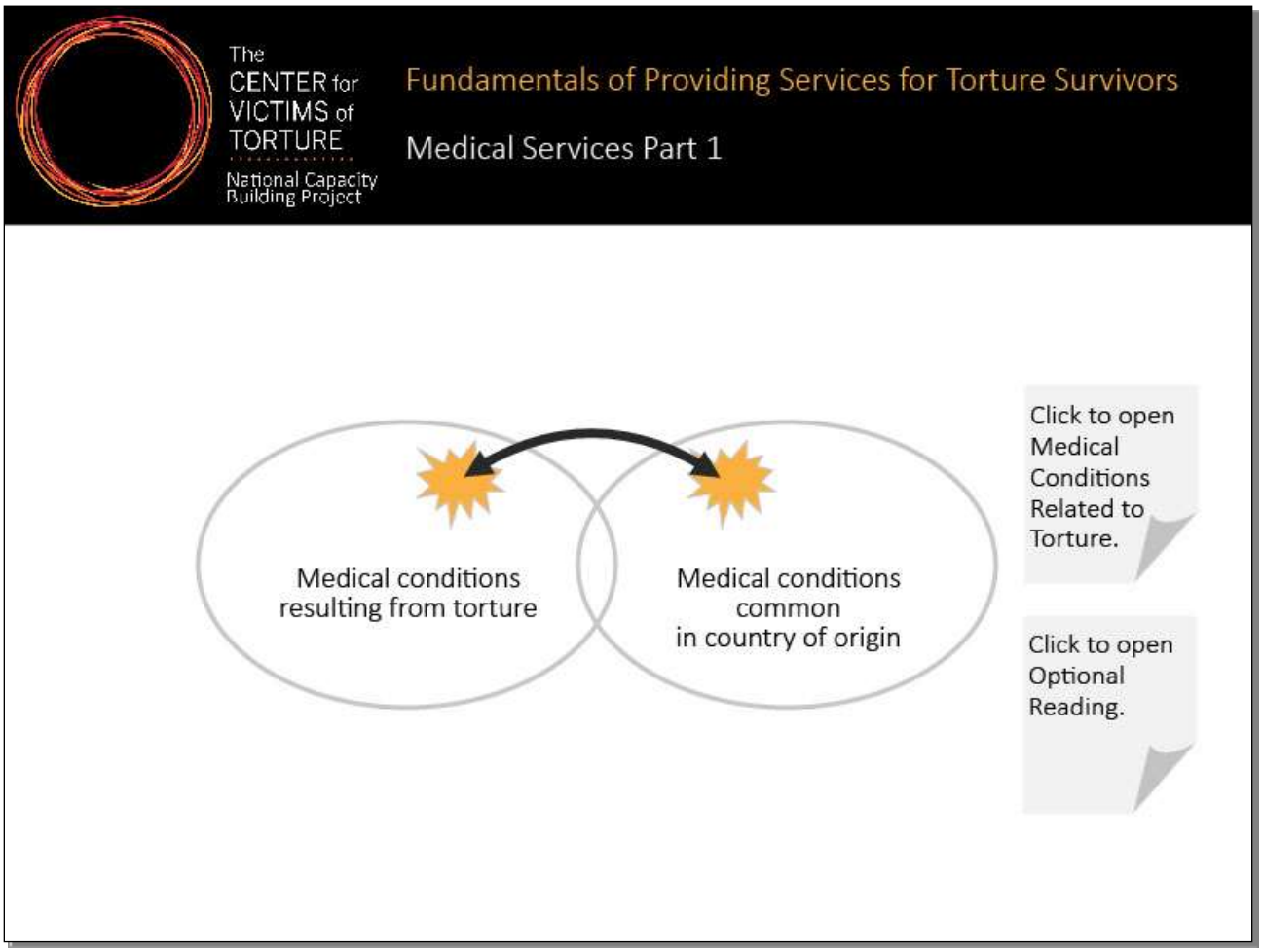
Now, let's consider some examples of common torture techniques. Click on the link to access a list of common torture techniques. This list is not intended to be fully comprehensive, but includes techniques commonly reported and techniques I have encountered in my clinical practice. Sometimes stories can be very distressing, and it is important to acknowledge this, to recognize that distress is a normal reaction, and to create a space to discuss your reactions with colleagues. It's likely that reading this list has some emotional impact. Take some minutes with your journal to write down your thoughts and feelings.

Slide 10 – Next: Medical Consequences



What are the medical consequences of torture?

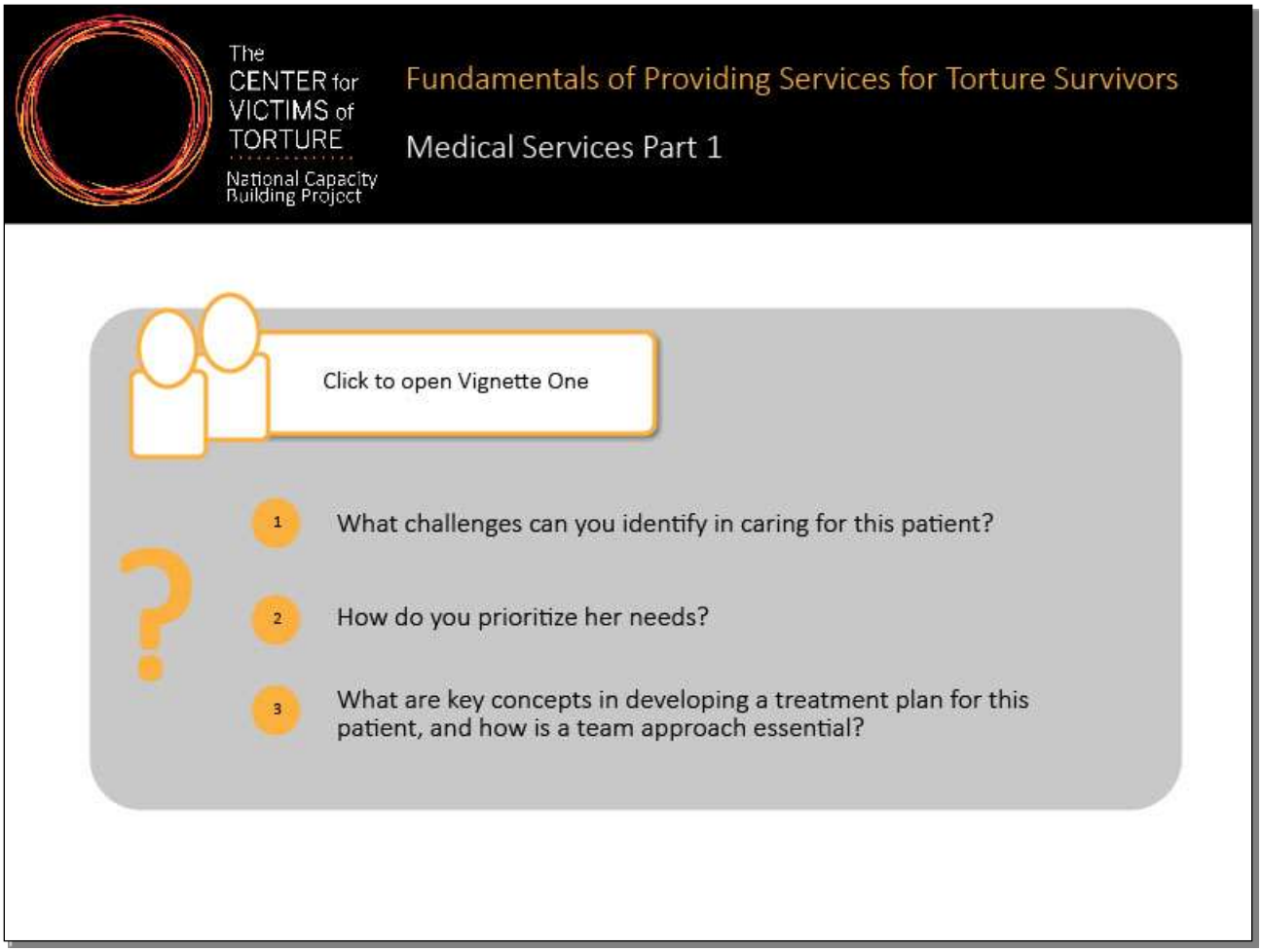
Slide 11 – Medical Conditions



It's important for healthcare providers to be familiar with specific medical conditions resulting from the experience of torture. In addition, these conditions may overlap with, and have impact on other health conditions, including those common to the countries of origin, i.e., malnutrition, tuberculosis, and vaccine preventable diseases such as measles. An example of this would be a survivor who suffers from chronic musculoskeletal pain from beatings and from tuberculosis of the spine. Malnutrition from food deprivation may be exacerbated by intestinal parasites that are endemic to the area. Medical conditions are also influenced by traumatic experiences, and psychological symptoms. Click the link to review a non-exhaustive list of the medical problems survivors experience.

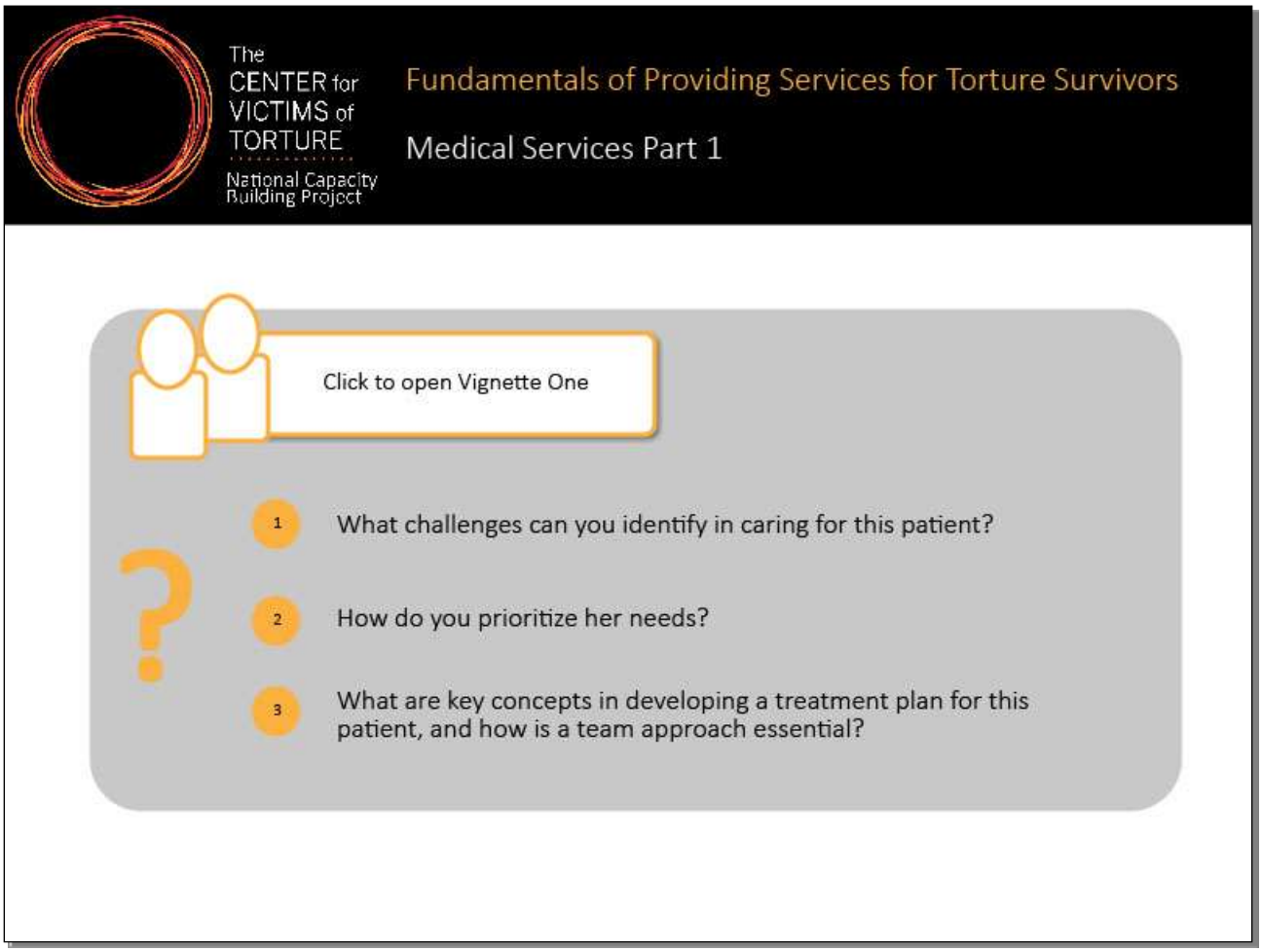
Next, to expand our overview on medical services, click on the grey document icon on far right to read selected pages from the NYU-Bellevue book, "Like a Refugee Camp on First Avenue." Click the grey box to go to this reading.

Slide 12 – Vignette 1



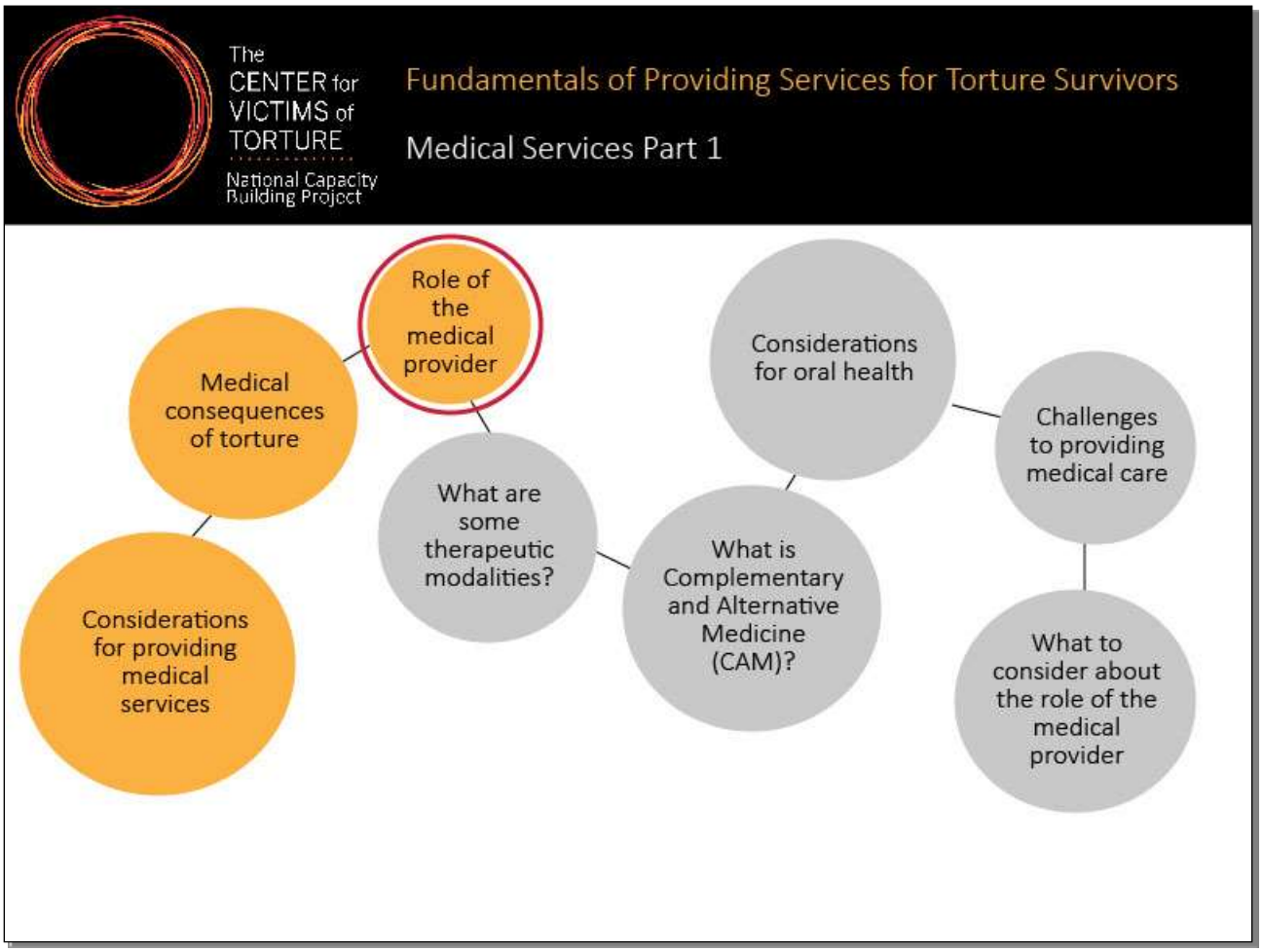
Now, let's apply what've you've learned to an individual survivor's situation. Listen to Vignette 1 and write your answers in your journal.

Slide 13 – Vignette 1 Part 2



[Audio narration of Vignette One]

Slide 14 – Next: Roles of Provider

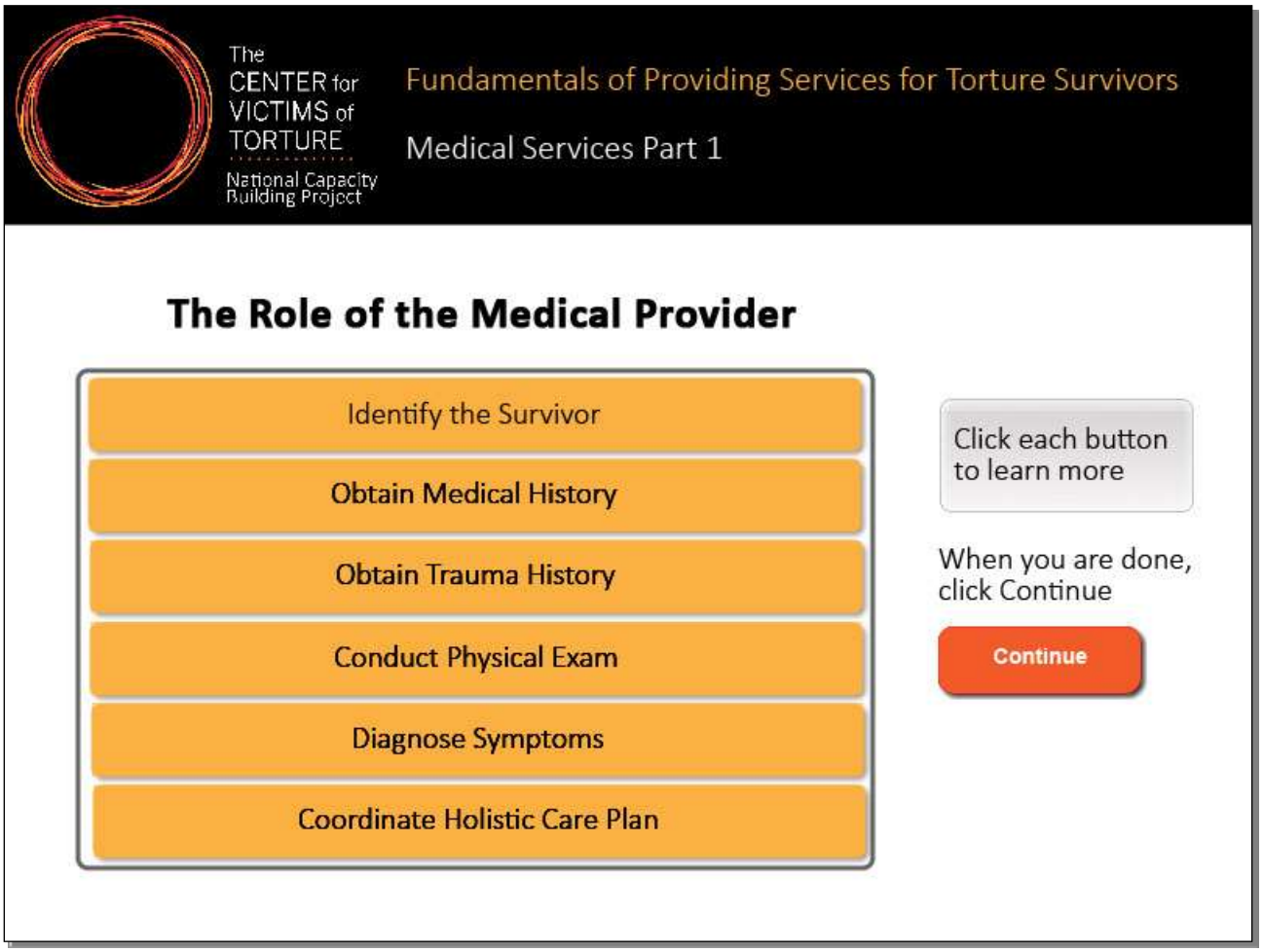


Next, let's discuss the role of the Medical Provider.

Slide 15 – Roles of Medical Providers

Before we continue, let me emphasize an essential underlying element to a medical provider's role. It cannot be stated too strongly that in many survivors, trust has been shattered, and reestablishing that trust may take time and patience. When addressing medical issues, providers must demonstrate attentive listening, empathy, respect, and pay careful attention to nonverbal cues. Of course, these same principles apply for all service providers.

Slide 16 – Roles of Medical Providers Part 2

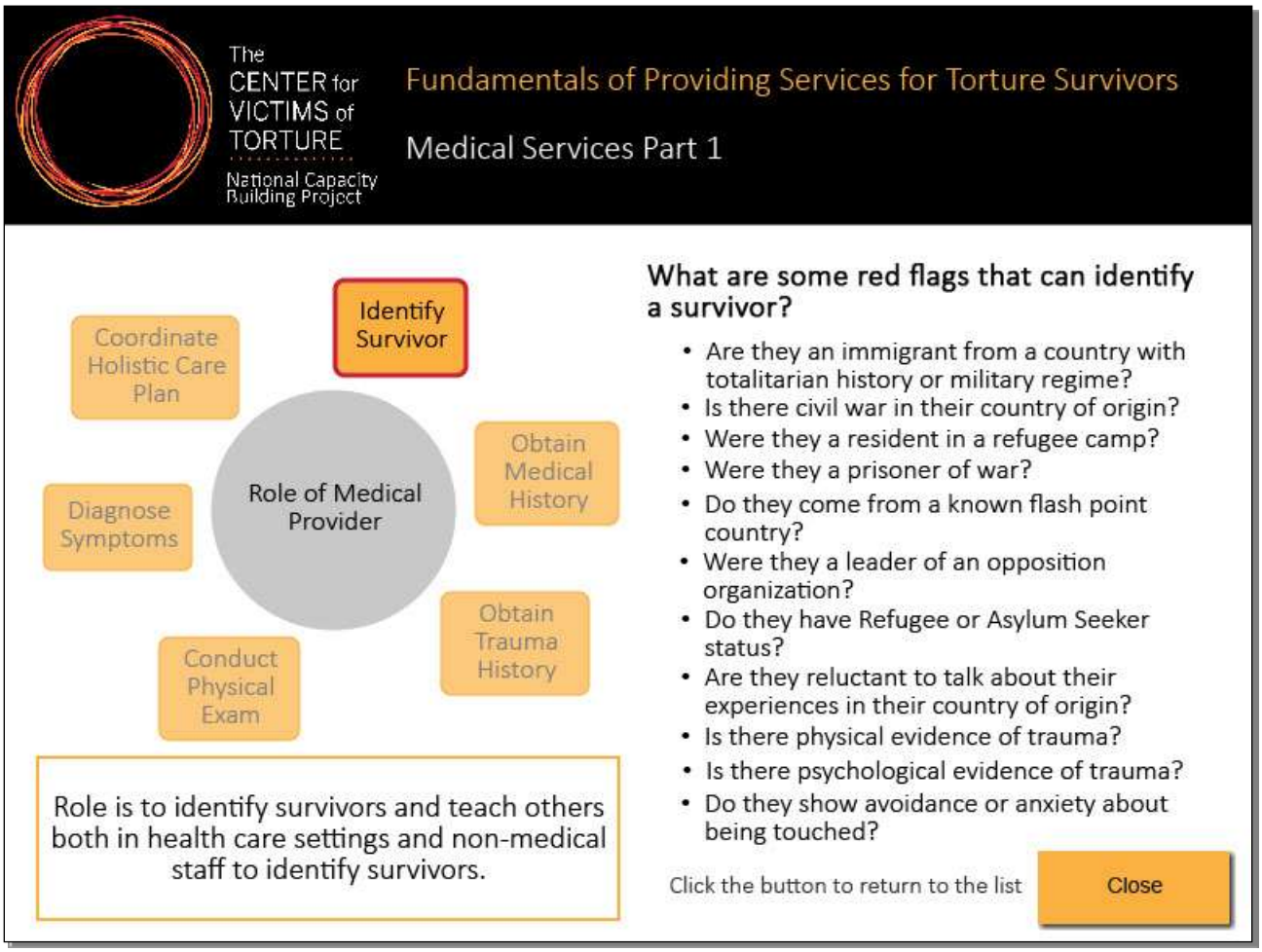


The role of the medical provider starts with identification of the survivor, and teaching others in the health care settings to identify survivors. Non-medical staff should also be aware of these factors, both for their own use and in educating community providers with whom they work.

In evaluating someone known or thought to be a torture survivor, taking a trauma history is particularly important. The physical exam also requires a special sensitivity and skill set. Diagnosing the cause of symptoms requires an understanding that physical and psychological symptoms may be, and often are, interdependent. Finally, and this point will be stressed throughout the course, the medical practitioner is part of a team that creates a holistic and comprehensive care plan that addresses all components of a survivor's needs. Established channels of communication and referral with service providers from other disciplines is essential.

Please click each button to learn more. When you are done, click continue.

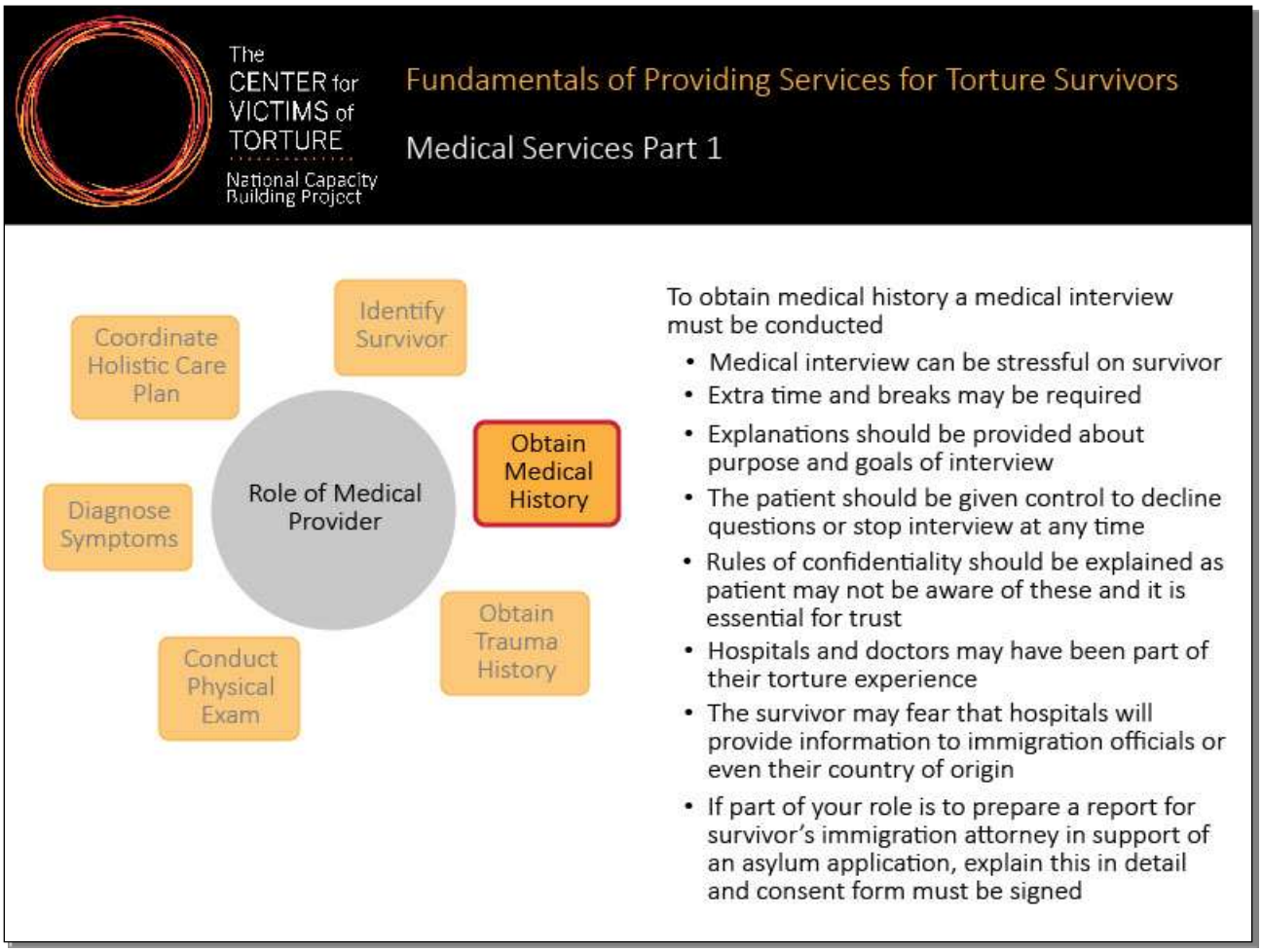
Slide 17 - - Identify Survivor



The role of the medical provider starts with identification of the survivor, and teaching others in the health care settings to identify survivors. Non-medical staff should also be aware of these factors, both for their own use and in educating community providers with whom they work.

- What are some red flags that can help identify a survivor presenting at a medical clinic?
- Are they an immigrant from a country with totalitarian history or military regime?
- Is there a civil war in their country of origin?
- Were they a resident in refugee camp?
- Were they a prisoner of war?
- Do they come from a known flash point country, such as Rwanda or Bosnia?
- Were they a leader of an opposition organization?
- Do they have Refugee or Asylum Seeker status?
- Are they reluctant to talk about their experiences in country of origin?
- Is there physical evidence of trauma?
- Is there psychological evidence of trauma or mental health symptoms?
- Do they show avoidance or anxiety about being touched?

Slide 18 - - Medical History



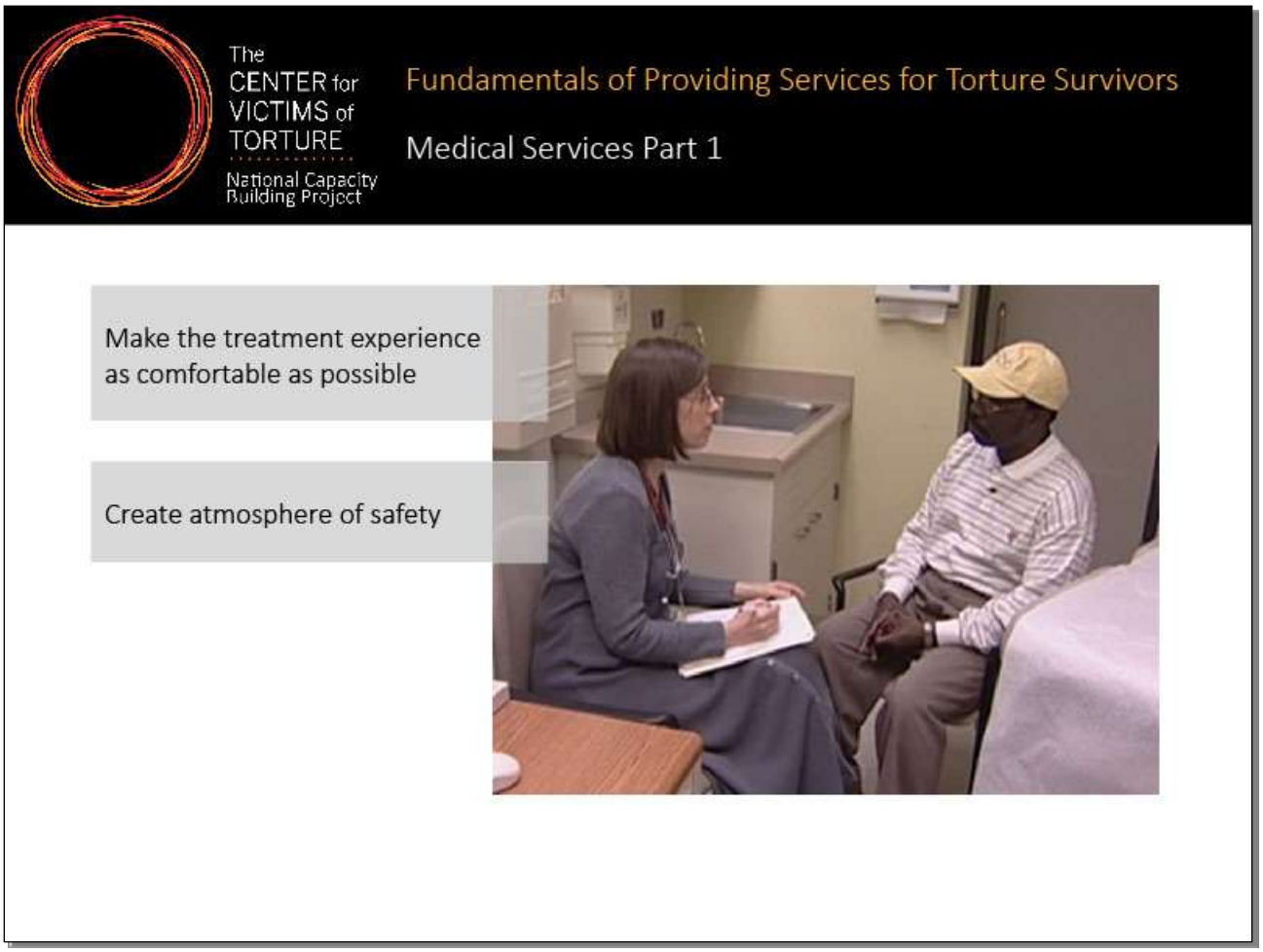
To obtain a medical history, a medical interview must be conducted. It can be stressful for the survivor. Extra time may be required, breaks may be necessary, explanations should be provided about the purpose and goals of the interview, and the patient should be given control to decline questions or stop the interview at any time.

At the outset, the rules of confidentiality should be explained to the patient as they may not be aware of these, and the issue is essential for trust. Hospitals and doctors may even have even been part of the torture experience. Many survivors, in fact, have reported physician involvement if their torture. The survivor may fear that hospitals will provide information to immigration officials or even back to countries of origin. If part of your role will be to prepare a report for the survivor's immigration attorney in support of an asylum application, this should be explained in detail and a consent form must be signed. Even with all of these protections, a survivor may not fully disclose their experience until months or even years have passed.

Slide 19 - - Comfort

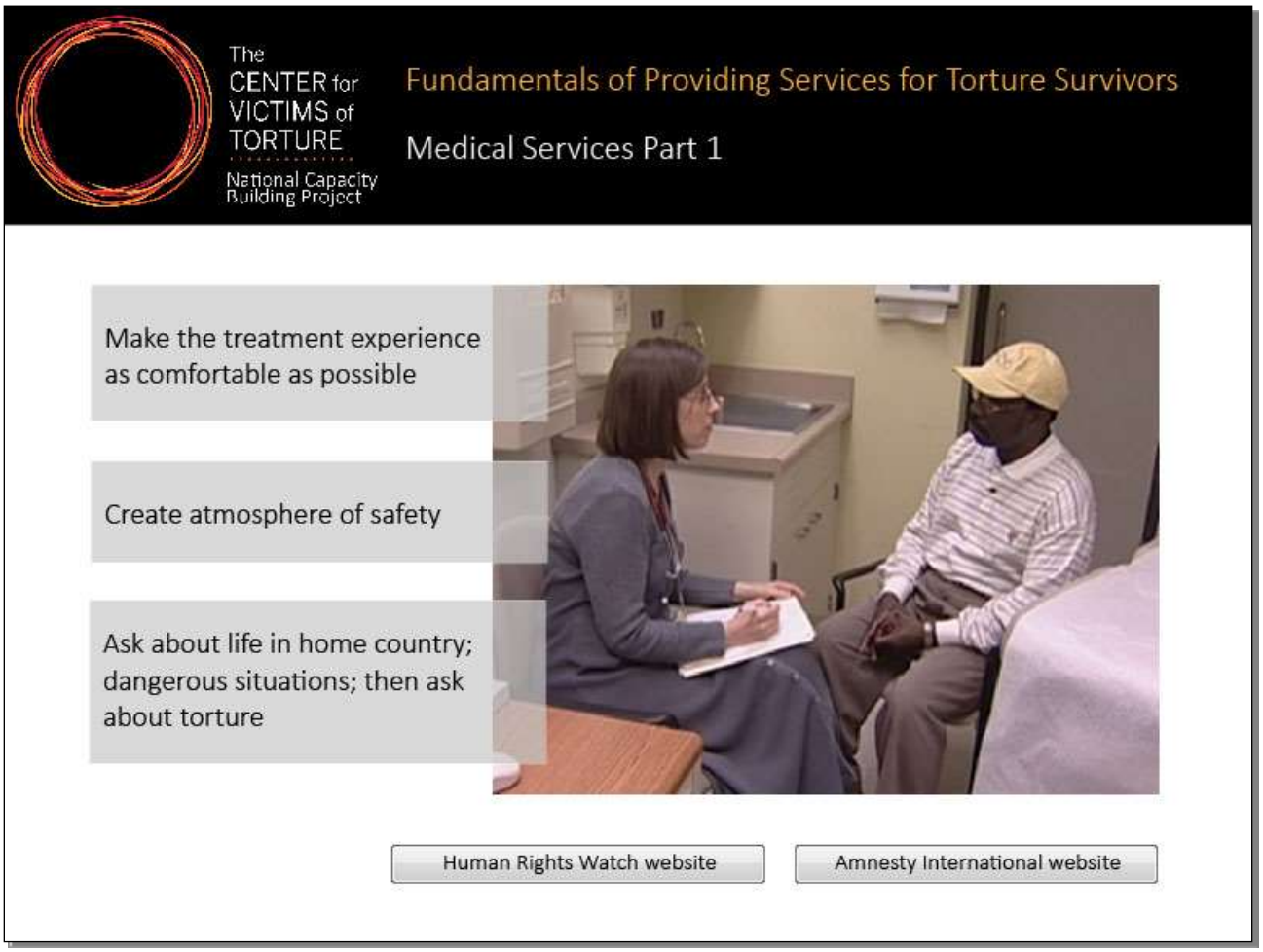
To make the treatment experience as comfortable as possible for survivors, there are many things to consider. If you are a non-medical provider making a referral or establishing an ongoing relationship with a clinic or hospital, you will want to bring these issues to their attention. Take time to orient them in detail. Long waits in the waiting room may be stressful, and should be minimized to the extent possible. The interview should take place in a comfortable setting. I try to reduce the power differential as much as possible by not wearing a white coat or having a desk create a barrier between us. They may well not feel safe or comfortable to tell us everything they endured at first, or even until much time has passed. Be patient and non-judgmental. Sexual trauma history (in men particularly) can be extremely difficult.

Slide 20 - - Safety



There is much to consider in creating an atmosphere of safety for both the interview and exam, since the environment may simulate the torture experience. Registration staff should be oriented, as asking for identification and immigration status can be frightening. Taking vital signs can be stressful. I've treated patients where the blood pressure cuff reminded them of being shackled. One man was reminded of being poisoned when a thermometer was put in his mouth. Keeping things in view and providing explanations for even simple procedures can minimize these reactions. Attempt to provide comfortable seating, and if preferred, keep the door open. Ask the patient what will make them comfortable. i.e. would they like water? Rapid fire questions can also create an environment of interrogation and should be avoided. I find that open ended questions work best, and then going back to fill in the gaps later. This approach often takes longer than a systematic approach, but fosters trust that you want to listen to their story.

Slide 21 - - Home Country



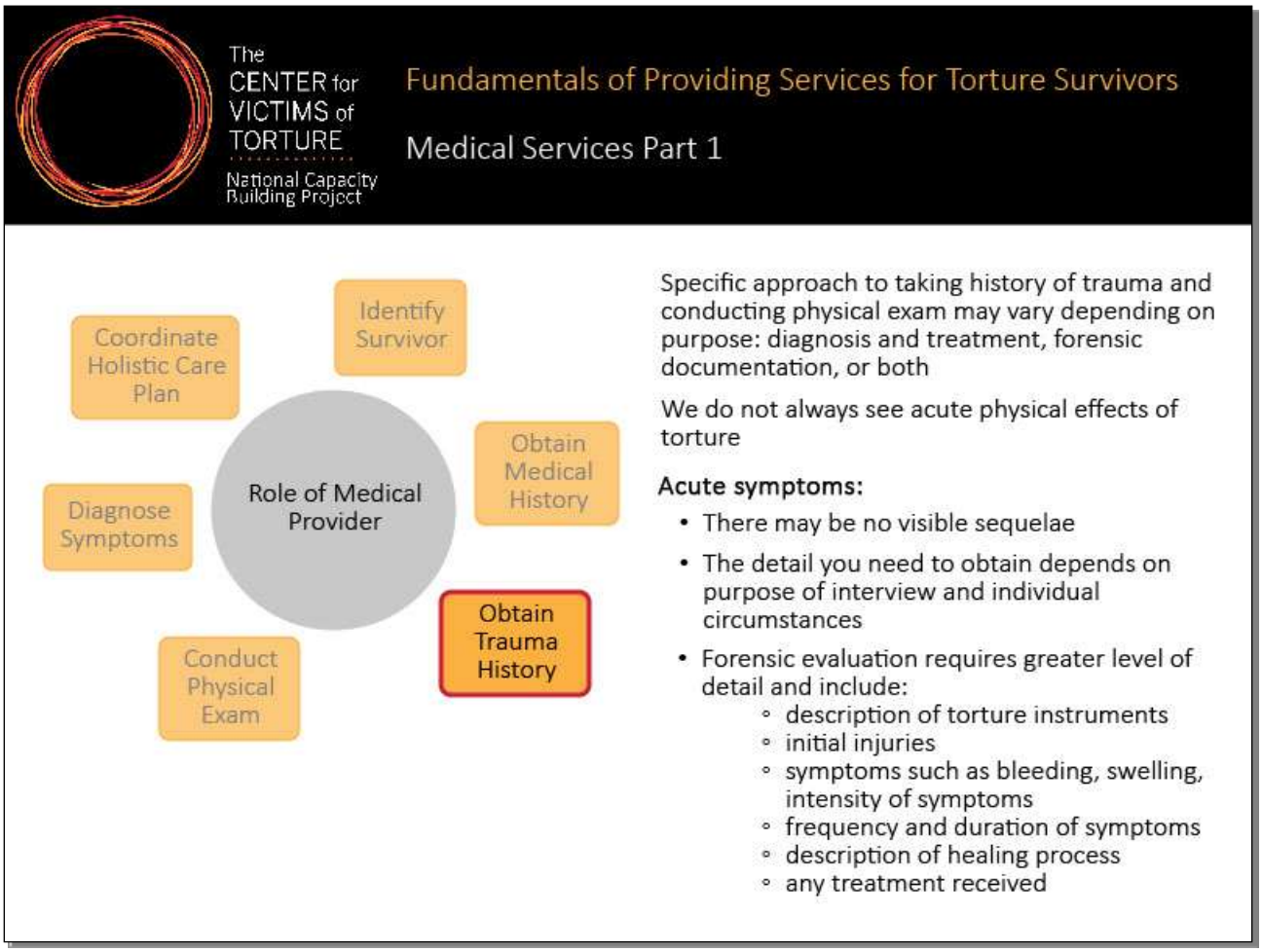
I am often asked by trainees how to ask a patient about torture. My approach is asking about life in the home country, how they escaped or left, and asking if they ever found themselves or their family in dangerous situations. It is very helpful to have some background information about conditions in your patient's country, so you can demonstrate a knowledge and interest in their homeland and situation. You could say, for example, "I know that some people from Cameroon who were members of the SCNC were arrested. Did anything like that ever happen to you?' Country condition information can be found on the Human Rights Watch or Amnesty International websites.

Slide 22 - - Complete History

Finally, the last component of obtaining a medical history is ensuring a complete record is obtained. Although many participants in this class are not medical providers and will not be directly performing these functions, it's important to be familiar with the process. Survivors are often very concerned about their physical health and you want to respect that concern and be able to make appropriate referrals.

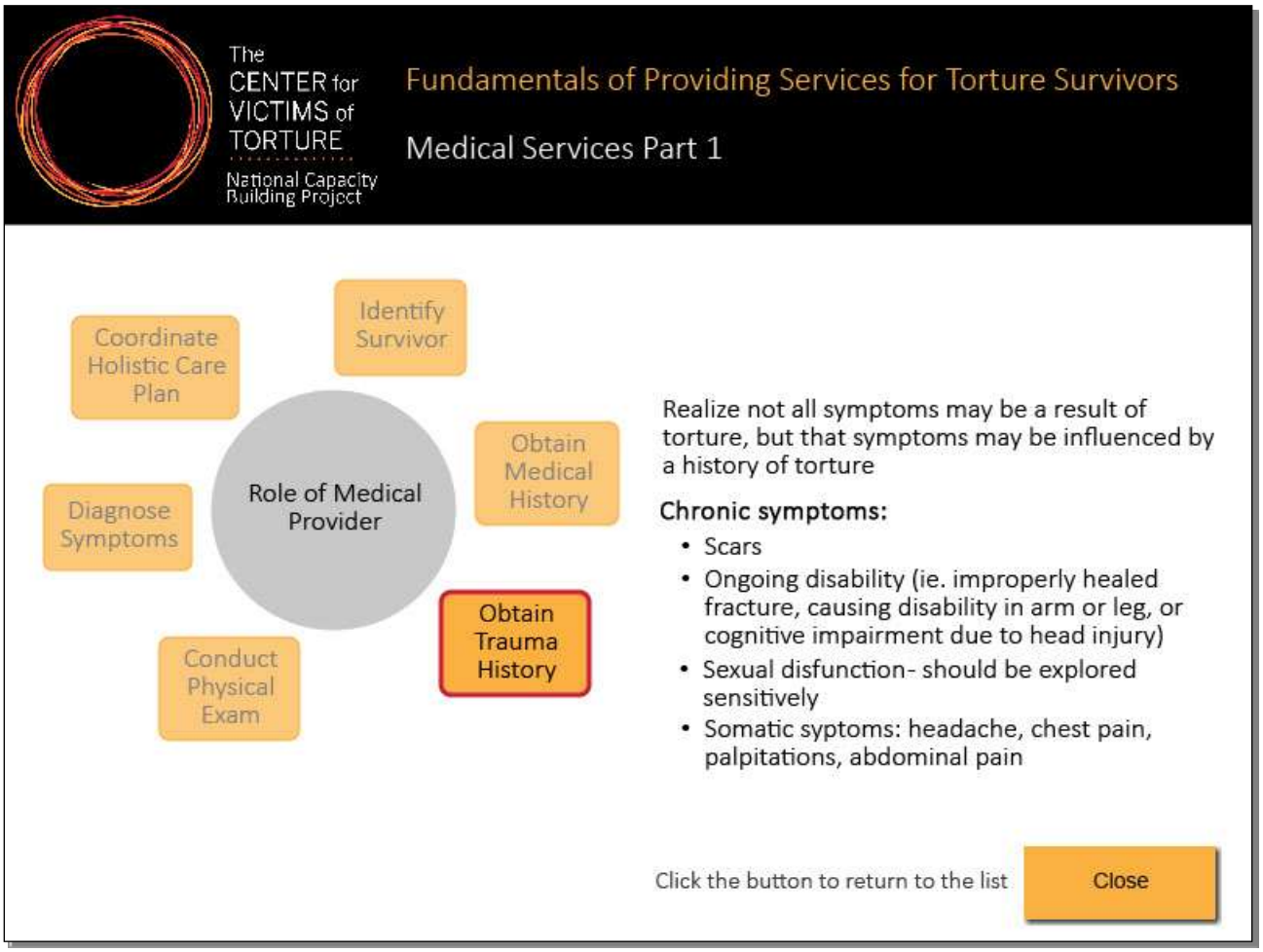
Medical history should include a detailed pre and post trauma medical history, illnesses and hospitalizations, medications including traditional treatments. For women it's important to ask about OB-GYN history and specifically about Female Genital Cutting, also called FGM or Female Genital Mutilation. A history of FGC may have implications for asylum. Family history for illnesses may or may not be known depending on the situation.

Slide 23 - - Trauma History



The specific approach to taking the history of trauma and conducting the physical examination will vary depending on the purpose, whether it's for diagnosis and treatment, for forensic documentation for the asylum claim, or for both. Keep this in mind as we proceed. We don't always see the acute physical effects of torture, as survivors often present after the initial injuries are healed. There may be no visible sequelae. The detail that you need to obtain about acute physical symptoms that the patient experienced after trauma depends on the purpose of the interview and individual circumstances. For instance, if I am performing a forensic evaluation documenting torture, the level of detail will be greater – and include description of torture instruments, initial injuries, symptoms such as bleeding, swelling, intensity of symptoms; frequency and duration of all symptoms; a description of the healing process and any treatment received.

Slide 24 - - Document Symptoms

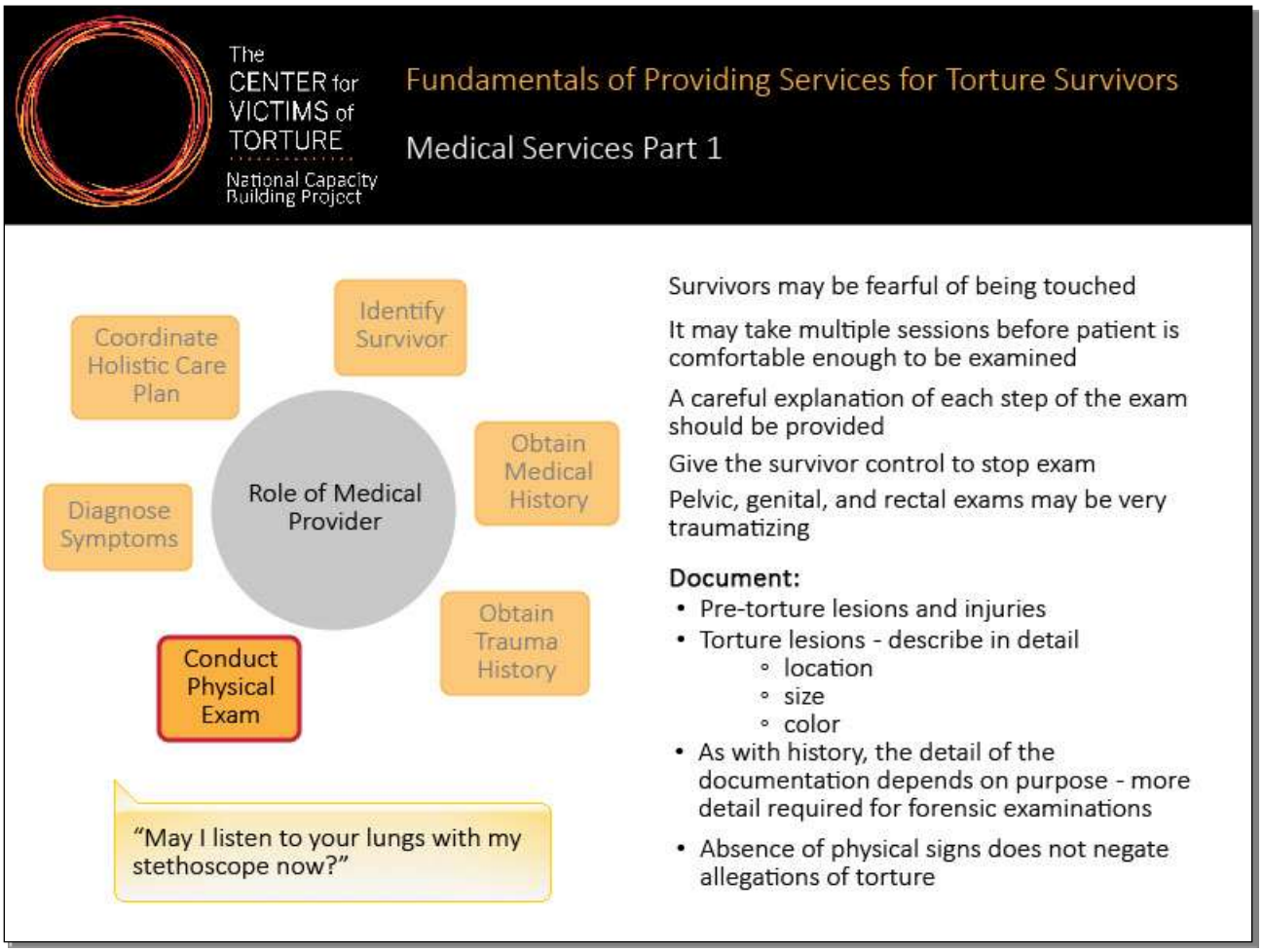


A history of chronic symptoms following torture should be obtained, realizing that not all symptoms may be a result of torture, but that symptoms may be influenced by a history of torture and interpreted by the survivor through the lens of the torture experience.

Scars will often be of particular concern to the survivor, as they serve as a constant reminder of the trauma. Is there any ongoing disability, such as an improperly healed fracture causing disability in an arm or leg, or cognitive impairment due to head injury?

Sexual dysfunction is common in survivors and should be explored sensitively.
Some chronic physical symptoms may be physical manifestations of psychological distress. In a consecutive series of 200 survivors presenting to a primary care clinic, 40% complained of chest pain or palpitations that did not have an identifiable organic cause.

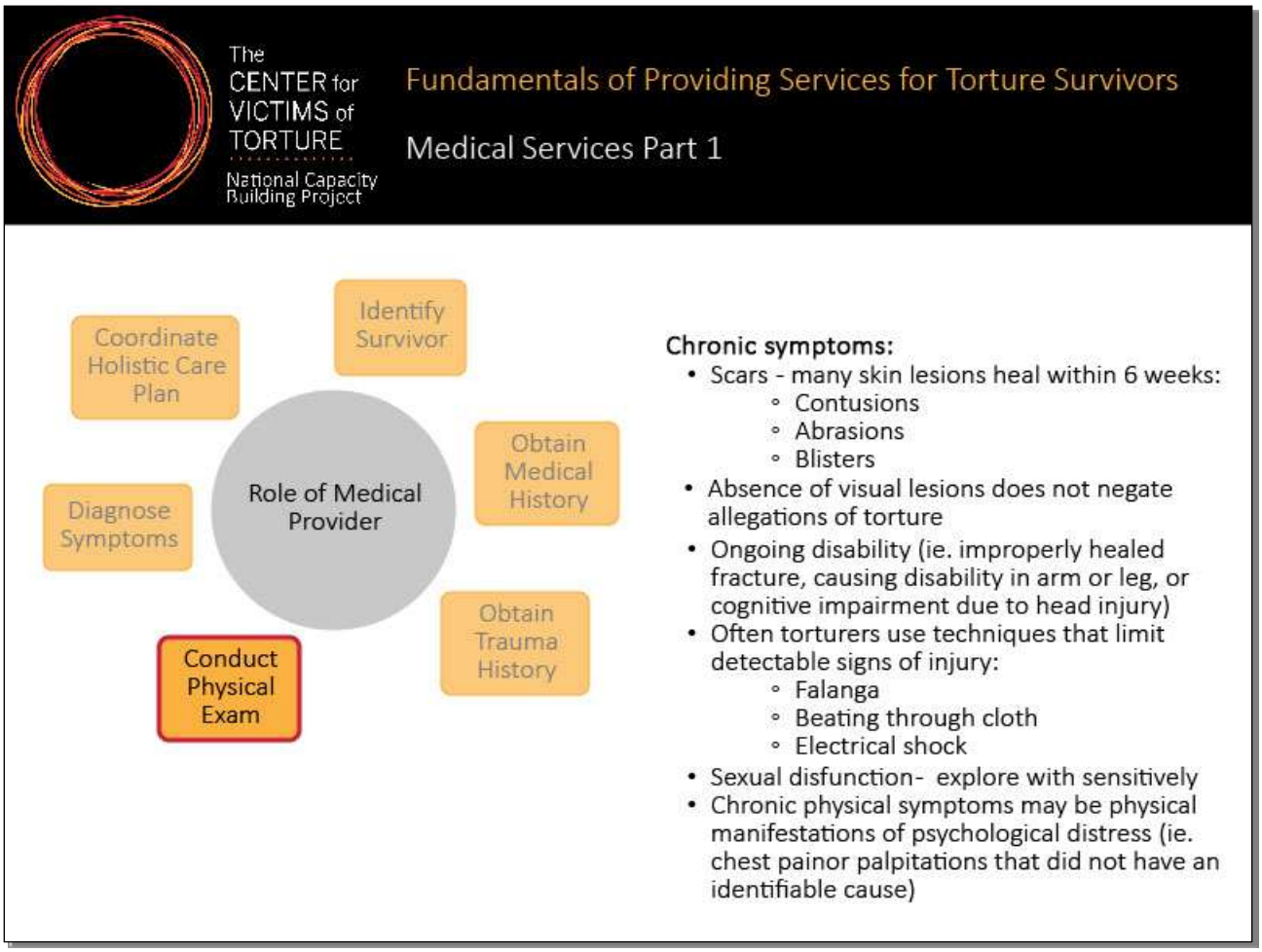
Slide 25 - - Physical Exam



Survivors may be fearful of being touched. It may take multiple visits before the patient is comfortable enough to be examined. When the survivor does consent to an examination, a careful explanation of each step of the exam should be provided —for example, an otoscope speculum inserted in the ear can be very startling. I will often ask permission as I proceed with the first examination: "May I listen to your lungs with my stethoscope now?" Give the patient control to stop the exam at any point. Pelvic, genital and rectal exams may be very traumatizing. I have had women survivors of sexual trauma who could not tolerate pelvic exams even after months, and ultimately the exams had to be performed under general anesthesia.

All pre-torture lesions and injuries should be documented, as well as the lesions/injuries due to torture. As with the history, the detail will depend on the purpose (much more detail is required for the forensic exam) Be aware that absence of physical signs does not negate allegations of torture.

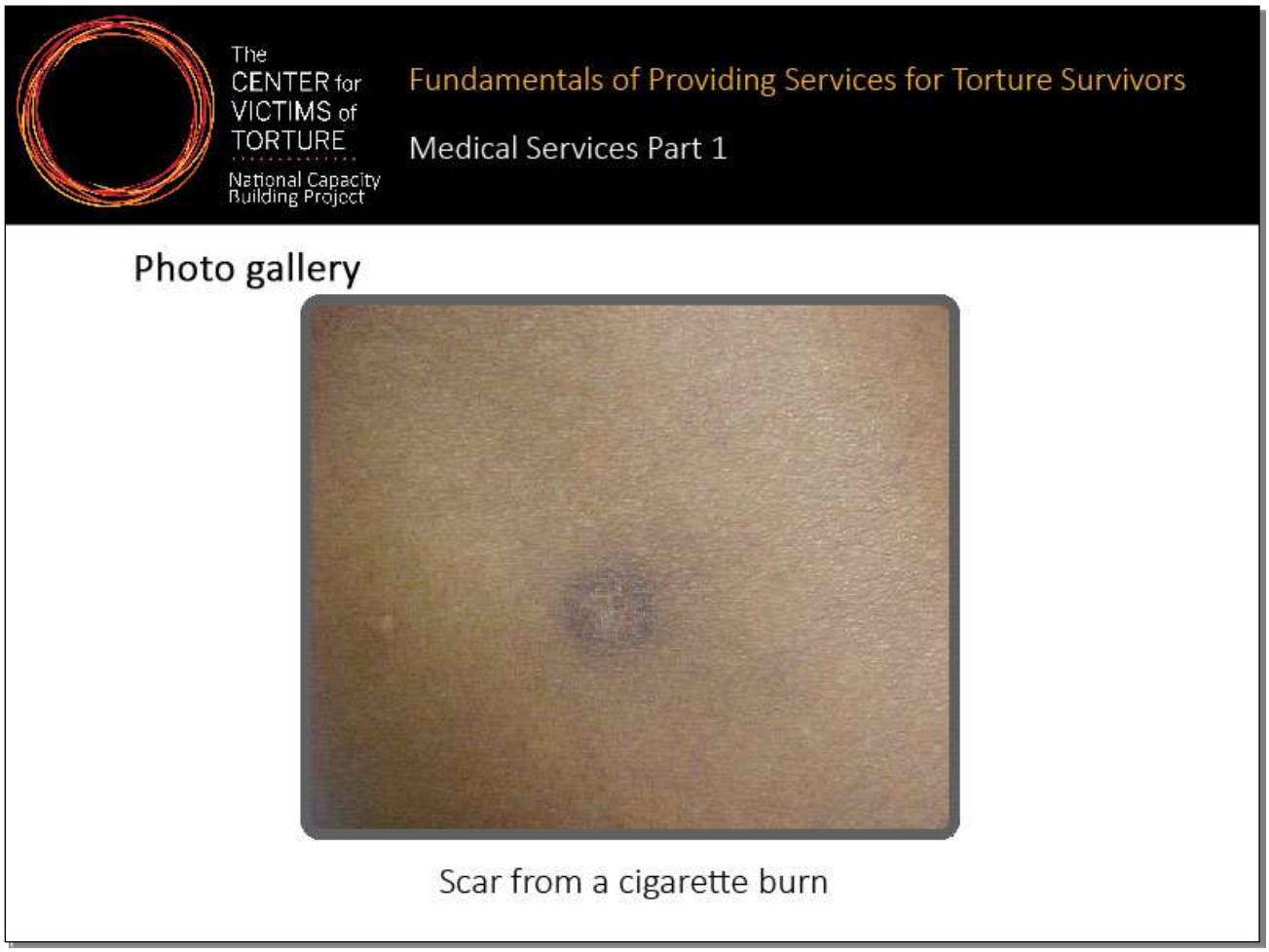
Slide 26 - - Scars



Many skin lesions that occur from injuries will heal without visible lesions (such as soft tissue injuries like bruising, and abrasions where only superficial skin layers are disrupted). An absence of visible lesions does not negate allegations of torture.

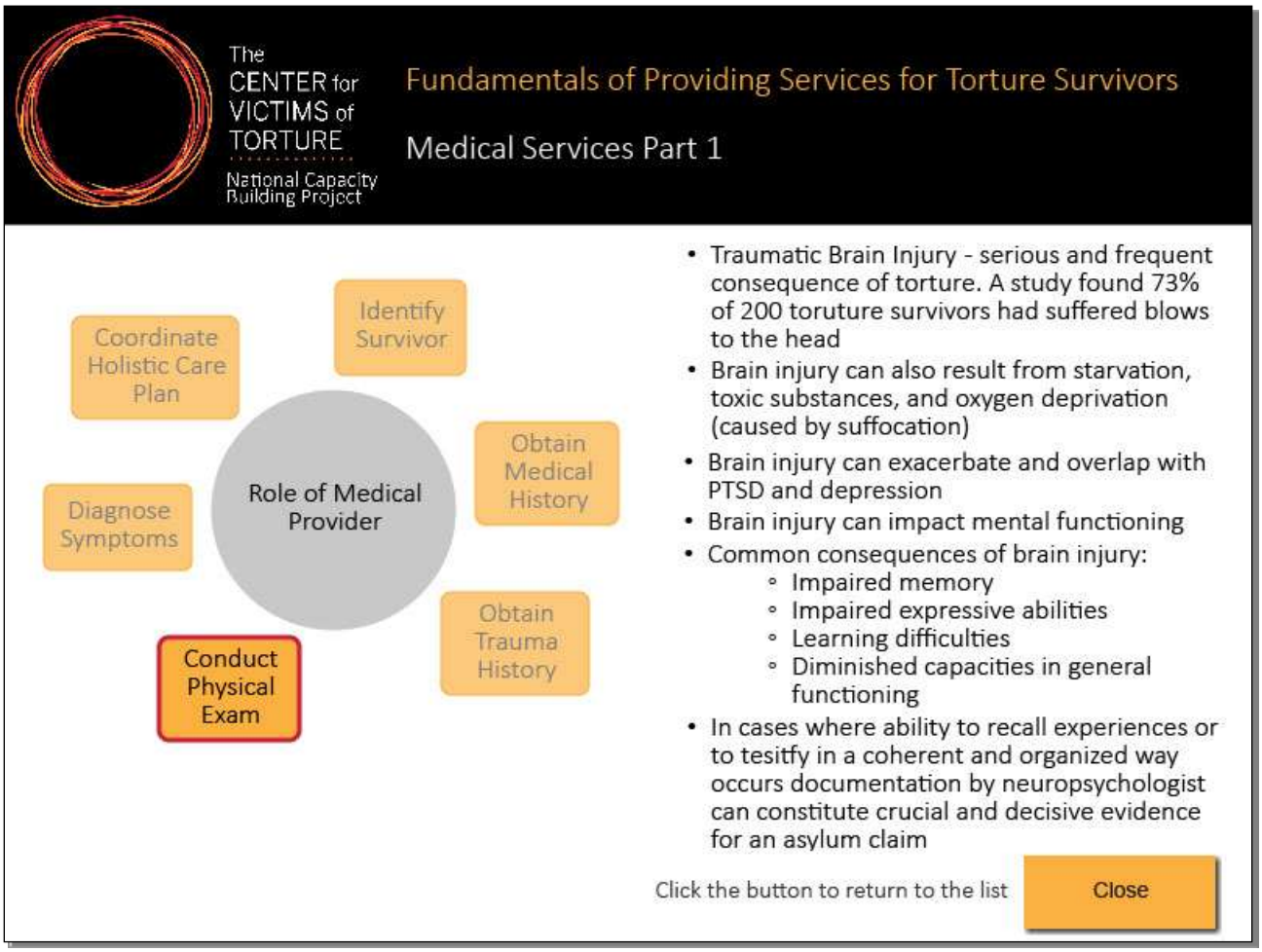
A description of the acute lesions and history of the subsequent healing process is very important evidence in corroborating specific allegations of torture. Often torturers will use techniques that limit detectable signs of injury - such as falanga, which is beating to the soles of the feet, beating through cloth, or administration of electrical shocks. Click forward to see a photo of a scar.

Slide 27 - - Photo: Burn



This is a typical appearance of a cigarette burn – this is fairly commonly seen, but can be missed if the examining professional is not familiar with it.

Slide 28 - - Considerations



Traumatic Brain Injury is a serious and frequent consequence of torture. One study found that 73% of 200 torture survivors had suffered blows to the head. Brain injury can exacerbate and overlap with both Post Traumatic Stress Disorder and Depression. Careful history-taking is essential, but may be challenging because the injury impacts mental functioning. Impaired memory, impaired expressive abilities, learning difficulties of various kinds, and diminished capacities in general functioning are common consequences of brain injury.

In addition to the obvious harm such damage causes, it can also pose a serious threat to torture survivors applying for asylum by impairing their ability to accurately recall experiences, including dates and locations, or to testify in a coherent and organized way.

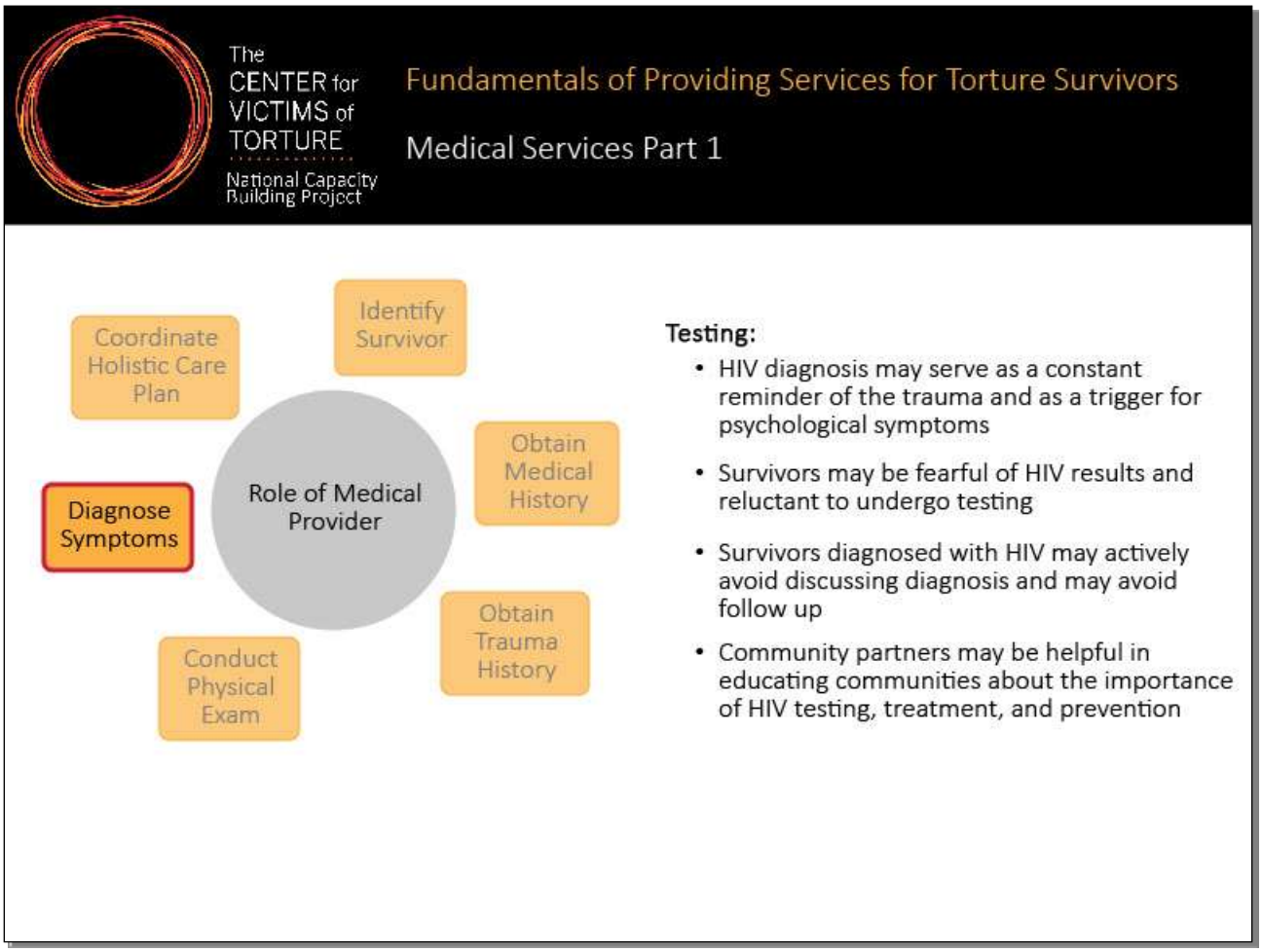
In such cases, documentation, ideally by a neuropsychologist, can constitute crucial and decisive evidence for a claim to political asylum, where the applicant might otherwise be found not credible. In one of my cases, neuropsychological testing revealed a subcortical dementia with impaired executive functions severe enough to explain the survivor's failure to file for asylum within the one-year deadline. A pro bono attorney presented the evidence and the man was granted asylum.

Slide 29 - - Diagnose Symptoms

There are standard guidelines for immigrant medical screening available. See the Additional Resources for references. These guidelines include screening for infectious diseases such as TB, parasites, syphilis, HIV and Hepatitis B. Specific tests will depend on the country of origin. Vitamin D Deficiency is common and may contribute to generalized musculoskeletal pain.

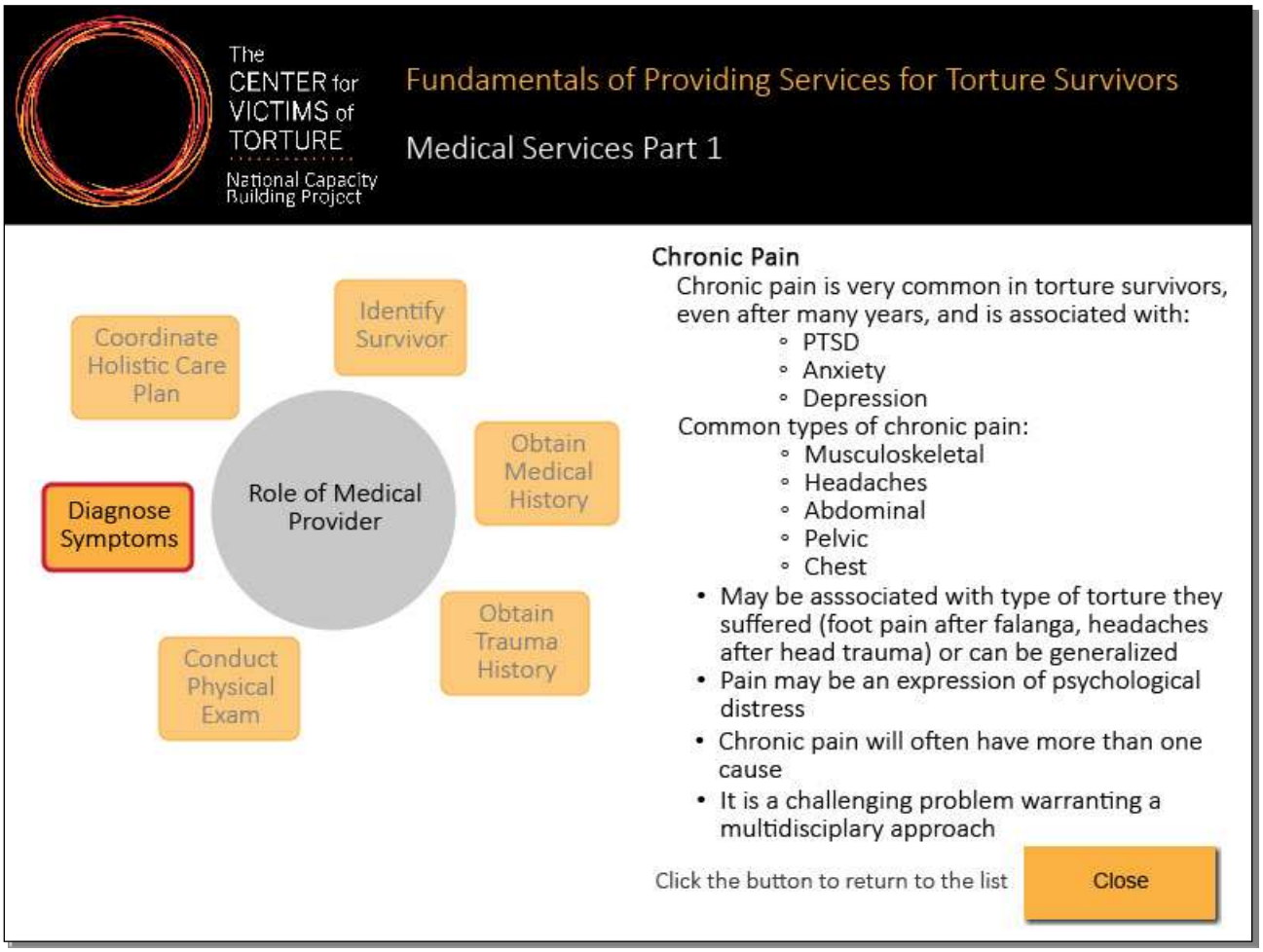
Refugees and asylum seekers may come from countries where congenital heart disease is not diagnosed and treated early, and acquired heart disease such as rheumatic heart disease is more common. Of course, cardiac symptoms such as chest pain and palpitations may overlap with symptoms of anxiety and PTSD.
Other screening recommendations include dental screening, nutritional screening and assessment, and age and gender based preventative health screening. The concept of preventative health may be completely unfamiliar to the refugee and additional time and effort may be needed to educate patients about preventative health and the rationale for screening tests.

Slide 30 - - Testing



To survivors exposed to HIV through sexual trauma or contaminated torture instruments, an HIV diagnosis may serve as a constant reminder of the trauma and as a trigger for psychological symptoms. Survivors may be fearful of HIV results and reluctant to undergo testing. Survivors diagnosed with HIV may actively avoid discussing an HIV diagnosis and may avoid coming in for care. Of a cohort of 34 HIV infected refugees, 35% were exposed to HIV as a result of torture, although it is not usually possible to definitively determine the source of infection. Community partners, including communities of faith, may be helpful in educating communities about the importance of HIV testing and treatment, including safe sexual practices to avoid transmission of the virus.

Slide 31 - - Chronic Pain

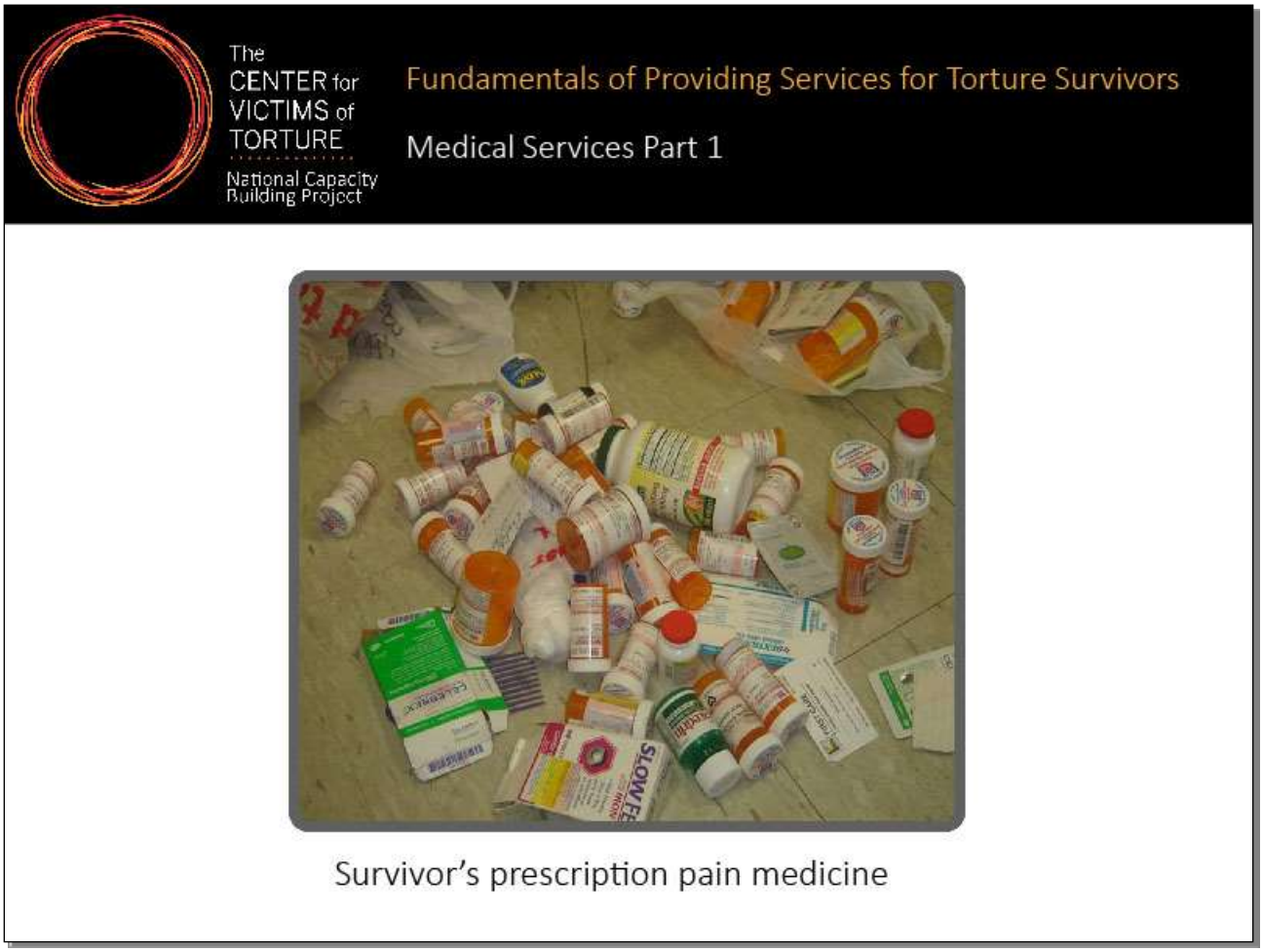


Chronic pain is very common in torture survivors, even many years after the trauma, and is associated with elevated PTSD, anxiety and depression scores. Common types include musculoskeletal pain, headaches, abdominal pain, pelvic pain and chest pain. Pain may be associated with the type of torture they suffered (i.e. foot pain after falanga, headaches following head trauma) or can be generalized. Pain may also be an expression of psychological distress. Often, chronic pain will have more than one cause, and a careful evaluation is warranted. Chronic Pain is a challenging problem warranting multidisciplinary approach.

Slide 32 - - Coordinate Plan

I'll remind you here that all services for torture survivors require a holistic approach. In medical care, this approach recognizes the interrelationship of the mind and body. It aims to restore the overall balance in mind-body system and views health as an ongoing process, which encompass physical, psychological and social factors. We have to look beyond the strictly physical aspects of healing.

Slide 33 – Client Experience with Other Providers



Finally, when thinking about a holistic care plan, consider the experience the survivor has had with other providers. This photo illustrates a case of misdiagnosis and dangerous polypharmacy in a torture survivor who presented to multiple doctors, clinics, and emergency rooms seeking relief from her severe chronic pain. She was eventually referred to our center by a member of her community, and during her first visit, dumped a bag of over 60 prescription pain medicine bottles onto the floor of my clinic. Fortunately, she was not taking any of the medications because she could not read the instructions, which were all in English. Not one of these prescribers had taken an appropriate trauma history or performed a thorough mental health evaluation.

The patient was diagnosed with severe Post Traumatic Stress Disorder and somatization, as well as mild knee arthritis, and was referred to appropriate mental health care. This is what you want to avoid --misdiagnosis of pain in torture survivors which delayed treatment and prolonged her suffering, in addition to dangerous polypharmacy which could easily have resulted in tragedy. If you are a non-medical provider, you will want to know if and where the survivor you are serving is receiving medical treatment. Preferably, with the survivor's consent, a medical provider affiliated with you program can become involved.

Slide 34 - Proceed to Medical Services Part 2