

ETHICS CASE

Taking Up the Mantle of Human Trafficking Education: Who Should Be Responsible?

Commentary by Carrie A. Bohnert, MPA, Aaron W. Calhoun, MD, and Olivia F. Mittel, MD, MS

Abstract

Human trafficking is a global human rights issue with long-range health consequences about which physicians are largely uneducated. Medical schools are uniquely positioned to address this gap. All future physicians, regardless of specialty, must learn to identify victims and refer them to trauma-informed treatment. Research and advocacy are needed to address the lack of rigorously evaluated curricula in this area, impact policy, and improve services for victims of this heinous form of exploitation.

Case

It's a busy summer night in the emergency department. You have seen 15 patients so far, and the fourth-year acting intern is approaching you with the sixteenth. He describes the patient as a young woman complaining of dysuria and increased urinary frequency whose history of present illness and physical exam are suggestive of cystitis. After discussing appropriate antibiotic and follow-up plans with the acting intern, you make your way to the bedside to confirm the student's findings. But before you can open the door the student stops you with additional concerns.

"She seems younger than eighteen," he says, "and I get the feeling she wasn't telling me the truth about her social situation. I also noticed a few poor-quality tattoos that look homemade on physical exam. This made me suspicious, so I searched through her medical history. It looks like she's been here at least three times in the last several months for other complaints. She had a sexually transmitted infection (STI), a broken finger, and an eyebrow laceration. When I asked her about the injuries she was evasive and said she was clumsy. She seems sober now, but other physicians have noted that she was high on previous presentations. I may be way off base here, but I'm worried that she's being exploited. We learned about human trafficking last year, and this patient is showing several red flags."

The student shows you some information online about the prevalence of human trafficking and its associated symptoms, and you decide to call the National Human

Trafficking Resource Center (NHTRC) hotline. What seemed like a cut-and-dried case has now become much more complex. This new information has made you wonder if you have missed these signs in the past with similar patients.

Commentary

Human trafficking is defined as the use of force, fraud, or coercion to induce a person into labor or commercial sex acts [1]. It has a prevalence of 20.9 million people in any given year [2], generating over \$150 billion in profits annually for traffickers [3]. Victims are most often employed in domestic labor, agriculture, manufacturing, construction, or sex work [3]. Statistics from the NHTRC indicate that human trafficking is a nationwide problem in the United States, with substantiated reports of trafficking originating from all 50 states in 2015 [4]. In 2014, the *Washington Times* reported that human trafficking surpassed drug trafficking as the most profitable criminal enterprise [5]. Traffickers recognize that a drug can only be sold once but a human can be sold multiple times a day, every day of the year, for several years. Given the domestic prevalence of trafficking, it is imperative that future physicians learn to recognize and address the problem. The remainder of the article will use the case to address the relevance to clinical care of human trafficking content, acknowledge barriers to providing it, and assert the need for it in undergraduate medical education.

Relevance to Care

Clinicians practicing in primary care or acute care settings represent an optimal point of intervention. In Lederer and Wetzel's 2014 study of sex trafficking survivors, 99.1 percent of interview respondents reported having at least one physical health problem requiring professional evaluation while being trafficked, and 87.8 percent of respondents reported interacting with health care professionals while being trafficked [6]. Yet studies of clinicians' preparedness to identify trafficking victims demonstrate significant deficits in their knowledge. In one study, only 4.8 percent of emergency clinicians felt some degree of confidence in their ability to identify a victim of human trafficking [7]. A survey of physicians, nurses, physician assistants, and social workers indicated that 63 percent of respondents had no training in victim identification [8].

Patients who are trafficked experience such a wide variety of health complaints that it is difficult to develop a "profile" or picture of a typical patient. Victims have reported physical, psychological, and reproductive health problems and may present to any subspecialty due to the variety of their health complaints. Physical symptoms include, but are not limited to, injuries from assault, insomnia, migraines, malnutrition, abdominal pain, chest pain, and respiratory difficulty. The [psychological toll](#) of trafficking includes posttraumatic stress disorder (PTSD), depression, shame, guilt, nightmares, flashbacks, and drug and alcohol addiction. Among reproductive complaints, victims reported sexual violence, unwanted pregnancy, STIs, miscarriages, and forced abortions [6, 9, 10].

To ensure that every practicing physician, regardless of specialty, is adequately prepared to serve victims, every medical school should include human trafficking content in its curriculum. Physicians should also have the ability to provide [trauma-informed care](#), which emphasizes nonjudgmental language, privacy, and confidentiality to develop trust, with the understanding that traumatic events are often linked to overall health [11-16]. In this way, each graduating medical student will be prepared to recognize and respond to human trafficking.

Challenges and Barriers

A number of barriers stand in the way of the medical community's ability to effectively address this issue, both in terms of understanding the health care management of the patient and the ability to provide trauma-informed care. These barriers exist at the individual, professional, and societal level.

Individual-level barriers. Among individual practitioners, the greatest challenges to caring for this population are a lack of awareness of the prevalence of trafficking, an inability to identify victims of human trafficking, and a lack of appropriate communication techniques. Many victims are accompanied by their traffickers, who may fill out all paperwork and speak on behalf of the victim [9, 17]. It is also important to note that victims will likely have a strong sense of fear or shame regarding their abuse and thus may not disclose even when the trafficker is not present [9]. Clinicians' identification of trafficking victims thus requires their active consideration of social cues as well as physical symptoms. If any of the telltale signs and symptoms of trafficking are present [6, 18], trafficking must be considered on the differential diagnosis (see table 1). In the case above, the student recognized a constellation of symptoms, which, together, led him to suspect human trafficking.

Table 1. Some common red flags associated with human trafficking [6, 18]

Physical
Malnutrition or dehydration.
Delayed health care.
Signs of physical trauma, including being beaten, punched, kicked, burned, stabbed, strangled, or shot.
Signs of sexual abuse.
Head or facial injuries.
Tattoos indicating that the victim is property.
Signs of self-harm.
Serials cases of STIs.
Signs of substance abuse.
Need for reproductive health services at a young age.
Behavioral
Accompanied by overbearing employer or other adult.
Conflicting or inconsistent history.
Depressed mood.
Reluctance to speak to clinician.

Professional-level barriers. There is a distinct lack of validated [curricula on trafficking](#) for physicians and other allied health care professionals. One review identified 18 resources targeted to the wider audience of health professionals but only one publication on domestic violence and trafficking intended for physicians. In addition, few of these resources were evaluated through educational research and none provided evidence of subsequent behavior change [19]. Our own team at the University of Louisville has addressed this lack through the creation of the Medical Student Instruction in Global Human Trafficking (M-SIGHT) program [20–22]. M-SIGHT is a multimodal human trafficking curriculum that addresses signs and symptoms of human trafficking, trauma-informed communication, and resources for referral. M-SIGHT is intentionally embedded in a core clerkship, ensuring that all medical students receive the program’s content. The curriculum remains to be rigorously validated; however, pilot data show increases in learners’ ability to define human trafficking and their confidence in identifying victims [20–22]. Further research is needed to determine its long-term impact on learner behavior.

Societal-level barriers. The societal barriers are perhaps the most pervasive and difficult to address. Trafficking persists because there is demand for inexpensive labor and commercial sex. While improved identification of victims is imperative, it is also important to recognize that we cannot end human trafficking by recognition alone. Instead, we must become more vocal advocates and generous donors, working to create more shelters for victims, promoting trauma-informed care, lobbying for [safe harbor laws](#) in every state, and advocating for evidence-based criminal justice policies known to decrease demand for trafficking and tougher sentencing for traffickers and those who knowingly perpetuate demand. Progress to end human trafficking has been crippled by a siloed approach in which medical professionals, social workers, law enforcement, and other interested institutions are effectively isolated from one another. Surmounting these barriers will require a cohesive approach that mobilizes survivors, clinicians, and the professionals listed above in a way that compels legislative change and allocates more resources for victims.

Future Goals

There is a pressing need for further research. Such research should focus on better understanding the psychological and social factors that contribute to demand for human trafficking and susceptibility to victimization. There is also a need for the development of additional undergraduate and post-graduate curricula, coupled with rigorous validation studies of the effects of these curricula on learners' clinical skills. Relatedly, improved assessment tools and cognitive aids to assist clinicians in identifying trafficking victims need to be developed and validated. Additionally, there is a need for research on the use of trauma-informed communication strategies in the doctor-patient relationship. Finally, longitudinal studies are needed to assess the effect of these tools on practice and on the patient experience of those victims of trafficking who access the health care system.

Conclusion

Just as medical educators took up the mantle of intimate partner violence, so they must take up the mantle of human trafficking. Medical schools are uniquely situated to address knowledge gaps by incorporating human trafficking content into the core curriculum. All future physicians will then be equipped to screen for human trafficking and will be more likely to consider it as they develop their differential diagnoses. With increased knowledge of this issue, future physicians will be better equipped to join in community efforts to advocate for victim services, engage in research endeavors, and ultimately contribute to the abolition of this global human rights violation.

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