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FROM THE EDITOR

Exploring the Nature and Scope of Clinicians' Obligations to Respond to Human Trafficking

A girl I grew up with became dependent on heroin after suffering sexual abuse at the hands of a family friend. She went to drug rehabilitation centers many times, but the numbing effects of the heroin kept pulling her back. Human traffickers found her at a party and put her on a plane with other girls to sell her for sex. She got her hands on a cell phone, contacted her father, and was eventually rescued by the FBI. She was lucky.

Human trafficking is one of the world's fastest growing crimes, according to the US Department of Justice [1]. Labor and sex trafficking has been reported in every US state, in both cities and rural areas [2]. Gathering reliable data is challenging, but there are an estimated 21 million trafficking victims worldwide [3], and approximately half of all transnational trafficking victims are minors [4]. Many victims are vulnerable to traffickers because of their histories of physical or sexual abuse, neglect, homelessness, poverty, or—in the case of minors—running away [5].

Many situations involving human trafficking are ethically complex, including victims' interactions with health care professionals. It is believed that 30-88 percent of US trafficking victims visit a health care professional at least once during their captivity [6]. The goal of this issue of the *AMA Journal of Ethics*® is to identify issues and challenges that health care professionals, policymakers, and advocates—drawing upon their professional authority and experiences—can use to build evidence-based practices and to motivate effective legislative and organizational policies to fight human trafficking globally.

Addressing human trafficking in medical education will be an important step forward. Within the past three years, at least 11 US medical and nursing professional associations have issued anti-trafficking statements and recommended education on human trafficking [7]. Standard medical training covers intimate partner violence, elder abuse, and child abuse, but not human trafficking [8]. In one survey, most medical students, resident physicians, and attending physicians reported that they lacked knowledge about the extent of trafficking and how to refer trafficking victims appropriately [9]. In this issue of *AMA Journal of Ethics*, Carrie A. Bohnert, Aaron W. Calhoun, and Olivia F. Mittel discuss the ethical imperative to support [human trafficking education](http://www.amajournalofethics.org) for all health care workers—starting at the student level—and the need for advocacy, research, and curriculum development.

As of 2016, only 14 states have enacted legislation that specifically covers sex trafficking in mandatory reporting laws [10]. This lack of specific legislation to guide health care professionals in ethically complicated situations leaves them vulnerable to performing illegal actions. Jonathan Todres examines the [legal consequences](#) of clinicians' assisting traffickers by treating women whom they know are selling sex and suspect might be trafficked. The lack of specific legislation and policy also raises questions about the consequences of various policy options for trafficked persons. Abigail English uses experience with mandatory child abuse reporting laws to evaluate the potential [benefits and risks](#) of harm to trafficked persons of expanding such laws to cover human trafficking. And Emily F. Rothman presents three models available for [policing commercial sex](#)—criminalization, decriminalization, and partial decriminalization—arguing a [different position](#) than Erin Albright and Kate D'Adama do in their contribution to this issue.

Although improving federal and state policies on human trafficking is crucial, there is a dearth of evidence-based research to guide new legislation. Rochelle Rollins, Anna Gribble, Sharon Barrett, and Clydetta Powell explain the importance of adopting a [public health perspective](#) on human trafficking and employing practice-policy feedback loops. These feedback loops, currently in their infancy for anti-trafficking work, make possible the evaluation and development of evidence-based practices to continuously improve both practice and policy. The creation of these evidence-based practices, however, requires better data. Patrick L. Kerr and Rachel Dash evaluate mandating disclosure of data from medical records, weighing the benefits of [more accurate data](#) against the risks of identification.

Given the lack of relevant education and guidelines, it's not surprising that in their everyday interactions with patients, health care professionals may lack the knowledge to identify trafficking victims or offer them the right kind of help and care. Wendy L. Macias-Konstantopoulos presents a [trauma-informed care framework](#) for the treatment of trafficking victims and survivors that incorporates the bioethical principles of respect for autonomy, beneficence, nonmaleficence, and justice. In their commentary on a case about a pregnant and possibly [mentally ill trafficking victim](#), Hanni Stoklosa, Marti MacGibbon, and Joseph Stoklosa discuss how a clinician can respond to these issues within a multidisciplinary, trauma-informed approach to care. And Monir Moniruzzaman reviews strategies for ethically intervening in a culturally unfamiliar context in commenting on a case in which a medical student discovers a victim of [labor trafficking](#) while on an international rotation.

Beyond their traditional scope of practice, physicians can assist with the prosecution of traffickers through documentation of human trafficking in war zones. Christina Bloem, Rikki Morris, and Makini Chisolm-Straker discuss whether disaster relief physicians

should create [records](#) that could be used to provide transitional justice and create accountability for traffickers. Closer to home, additional possibilities exist for health care workers interested in anti-trafficking advocacy. Terri Davis explores one such possibility: the risks and benefits to trafficking survivors of using their therapeutic artwork in [promotional exhibits](#) to raise awareness of human trafficking. As an example of such [therapeutic artwork](#), Margeaux Gray contributes two images to the project that are interpreted by Mary Richards. And in the podcast, Ranit Mishori discusses ways all of us can become [anti-trafficking advocates](#).

With an estimated 21 million trafficked persons around the world, why aren't more health care workers educating themselves, maintaining awareness, and advocating for anti-trafficking policies? William Polk Cheshire, Jr., encourages us to analyze our personal motivations and justifications in discussing why it's easy, even as health care workers, to be [oblivious to trafficking](#).

Anti-trafficking research, policies, legislation, and practice guidelines are all in their infancy. Yet all health care professionals have a moral imperative to actively work against human trafficking. There are many ways to help human trafficking victims and survivors, starting with awareness of the problem. This issue of the *AMA Journal of Ethics* contributes to that goal.

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ETHICS CASE

Saving the Starfish: Physicians' Roles in Responding to Human Rights Abuses in Global Health Practice

Commentary by Monir Moniruzzaman, PhD

Abstract

This paper examines how an overseas medical student can improve the life of a *kamlari*, an indentured servant girl in Nepal. I argue that physicians and students should not only provide care for the health and well-being of patients but also act to ameliorate the suffering of their patients, particularly when patients' social, cultural, economic, and political vulnerabilities overshadow their immediate clinical needs. I also address the point that medical schools need to offer courses on health advocacy and activism in order to promote health equity and social justice for all.

Case

Kathy, a medical student, traveled to Kathmandu, Nepal, during her fourth year for a global health elective. While in the clinic, the attending physician, a local Nepalese doctor, instructed her to examine a female patient while he spoke with her chaperone.

Through an interpreter, Kathy interviewed a 12-year-old girl named Laxmi who was holding her forearm wrapped in a shawl. The girl said her injury occurred when her "mistress" hit her with a stick as punishment for not cleaning the pots thoroughly enough. On examination of the wrist, Kathy noted bruising over the back of the wrist associated with significant point tenderness. She suspected a wrist fracture due to blunt force trauma.

Kathy asked the interpreter about the consequences to child abusers. He explained that nothing could be done, because Laxmi was owned by the person who abused her. He went on to tell Kathy about the local custom of *kamlaris*. In the 1950s, when migrants occupied their land and filed ownership papers, the Tharu people lost their ancestral farms. In exchange for allowing the Tharu people to keep their farms, the new owners demanded the Tharu families' young daughters as house servants. These indentured daughters are called *kamlaris* and those who own them are referred to as "masters" and "mistresses."

Laxmi told Kathy and the interpreter that she missed her parents and wanted to go home. She was fed only scraps from her owners' plates. And she was concerned for her safety because a girl from her village had been repeatedly raped by the junior master and then sent home in shame when she became pregnant. Laxmi had also seen a news story about a kamlari named Srijana who had been burned to death.

Kathy asked the interpreter if kamlaris were able to leave the owners' homes. The interpreter explained that the distance from Kathmandu to the country farms was too great for the girls to travel on their own. He also explained that, although the kamlaris system had been outlawed in 2006, the laws were not enforced for wealthy landowners. Unless Laxmi willingly left her owners, there was nothing they could do to stop the abuse. Kathy wondered what more physicians could do about these kinds of situations.

Commentary

We all can contribute to making positive change in this world, as the following story illustrates.

A young man is walking along the ocean and sees a beach on which thousands and thousands of starfish have washed ashore. Further along he sees an old man, walking slowly and stopping often, picking up one starfish after another and tossing each one gently into the ocean. "Why are you throwing starfish into the ocean?" he asks. "Because the sun is up and the tide is going out and if I don't throw them further in they will die." "But, old man, don't you realize there are miles and miles of the beach and starfish all along it! You can't possibly save them all, you can't even save one-tenth of them. In fact, even if you work all day, your efforts won't make any difference at all." The old man listened calmly and then bent down to pick up another starfish and threw it into the sea. "It made a difference to that one" [1].

Sick and injured people can be like starfish on the beach. Physicians are in a unique position to act like the older man who returns some starfish to the water by caring for sick and injured people and maybe helping to improve their lives. Physicians' roles are not limited to delivering health care for vulnerable people, but also involve [advocating](#) for their patients [2], especially when patients' clinical and social sufferings are intertwined. The American Medical Association's "Declaration of Professional Responsibility" reinforces these obligations, noting that physicians should "advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being" [3].

What does patient advocacy entail? Rudolf Vichow notes, "Physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction" [4]. Paul Farmer explains that the poor are at higher risk of contracting diseases and are

also less likely to have access to care; therefore, he urges physicians to make a preferential option for the poor, which means to serve the sick and work for their physical survival [5]. Noting that poverty, inadequate education, powerless positions, and insecure and toxic environments negatively impact health across the globe, Farmer and John R. Stone argue that physicians have a major responsibility to eliminate the “structural violence” of social inequalities [5, 6] “that greatly shorten lives and wreak so much suffering” [6]. Farmer defines structural violence as a form of social injustice that is silently built into social structures and institutions that systematically foster human rights abuses and extreme suffering [5]. His research shows how structural violence contributes to the plagues of tuberculosis and HIV/AIDS among the global poor, reducing both their access and adherence to effective therapy [5]. One example of structural violence is the lack of insurance coverage in the US prior to the implementation of the Affordable Care Act; the Kaiser Family Foundation notes that nearly 50 million Americans lived without health insurance in 2009, and 90 percent of them belonged to low- or moderate-income families [7]. Eugene C. Rich and colleagues argue that the role of physicians is to address the needs and concerns of the people who are most vulnerable; weakened by illness and injury; or distraught by the prospect of a loved one’s suffering, death, or disability [8].

All of these physicians argue that advocacy must be an integral part of medical practice and medical professionalism. Yet others challenge the scope of advocacy in medical practice by noting, “Advocacy must remain an occasional and optional avocation in academic medicine, not a universal and mandatory commitment” [9]. My position is that physicians cannot act as bystanders to the violence, inequality, and injustice around us but rather must advocate for health care of the impoverished populations whose socioeconomic conditions, such as food insecurity, inadequate housing, or domestic violence, impair their health directly. Physicians can also advocate for structural, [political](#), and educational changes that would ameliorate patients’ suffering. In other words, physicians cannot escape advocacy in their professional pursuits and should occasionally engage in activism as public individuals.

Consistent with this scholarship, in analyzing Kathy’s case, I argue that physicians, residents, and students ought to take an active role in providing for the health and well-being of patients. They have professional and ethical responsibilities to stand against the injustice to and suffering of their patients, even in culturally complex and sensitive situations—particularly when patients’ social, cultural, economic, and political vulnerabilities overshadow their immediate clinical needs. Physicians can do this by adopting the multilevel approach that I explain below in analyzing the case.

Duties of a Physician

As the health care worker caring for Laxmi, Kathy has several duties. First, she must examine Laxmi’s wrist injury and offer her medical care. However, medical care alone is

not sufficient to improve the life of Laxmi, who faces violence and suffering because of her status as an indentured servant. Kathy needs to assess the [abuse](#) Laxmi has suffered in order to determine her course of action. Kathy could discover that Laxmi has been subject to more extensive violence, injury, or abuse, i.e., sexually transmitted infections, pregnancy risks, and trauma. Kathy also needs to inquire what would be the possible consequences, under kamlaris, if Laxmi were to run away and get caught. What would be her position in her village if she returns to her parents?

Kathy then must ask Laxmi through the interpreter whether she is willing to leave her owner and return home. If Laxmi answers in the affirmative, Kathy should actively support her decision in order to protect her from further abuse and to improve her overall health and well-being. If Laxmi responds in the negative (which is unlikely, as Laxmi already asked to go home), Kathy may suspect that Laxmi's choice is coerced. In such a scenario, Kathy should understand Laxmi's point of view but reason with her to act as her advocate and persuade her to put together a plan of action (e.g., developing a safety plan, reporting the crime, or suggesting that Laxmi contact the trafficking advocacy groups by giving out their phone numbers [10]). Either way, Kathy should act in Laxmi's best interests, which is to protect her from long-lasting harm.

A challenge for Kathy is that her actions could inadvertently create a life-threatening situation for Laxmi. The owner could learn and reveal that Laxmi is trying to leave, putting her at risk for further violence and abuse. Kathy must assess the situation carefully. If she believes the potential risks are minimal for Laxmi, Kathy should directly intervene and assist Laxmi in returning home. If the risks outweigh the benefits, Kathy should still assist Laxmi but minimize Laxmi's risks by taking the multifaceted approach that I suggest below. In that case, it is important that Kathy not assist Laxmi on her own; rather, she needs to seek other professional and institutional support. Kathy could collaborate with Laxmi's family, the clinic where she was treated, and local nongovernmental organizations.

Family. Kathy can try to contact Laxmi's family by asking Laxmi for the telephone numbers and mailing addresses of her parents, relatives, or neighbors. If Kathy or designated staff can reach Laxmi's parents, she can inform them of Laxmi's injury and her decision as well as convey her own concerns to them. Laxmi's parents may ask for support from Kathy due to their lower socioeconomic status. Kathy can offer them advice, and she can connect them with legal officers and social workers who may be available and affordable for them. If Kathy is unable to reach Laxmi's parents, she should act for the beneficence of the child, the primary ethical guideline in pediatrics [11], by reaching out to others.

Clinic. Kathy should consult with the attending physician, explaining to him Laxmi's injury and abuse, and seeking his advice on how to assist the patient. She should explain to the

attending physician that the patient wants to leave her owner's home and that Kathy would like to support this desire to ensure the health and safety of the patient. It is important that Kathy be careful in approaching the attending physician, since he has already heard the chaperon's side of events. Kathy can review the case with other colleagues to evaluate how to handle the situation efficiently. Kathy can possibly meet with the hospital administrators and ask them to provide funds or transportation and support Laxmi by publicly using the authority of the institution to condemn the abusive kamlari system.

Nongovernmental organizations. One might argue that, as an outsider, or on behalf of the institution for which she works, Kathy should not intervene in this localized and complicated practice of bonded slavery. Regardless, Kathy is obliged to protect Laxmi from the consequences of abuse that adversely affect Laxmi's health. Therefore, Kathy, office staff, or hospital representatives can seek further collective assistance from governmental and nongovernmental organizations, such as Change Nepal [12], Forum for Protection of People's Rights Nepal [13], and Nepal's Common Forum for Kamlari Freedom [14]. These groups offer a range of legal, social, and personal support to the victims of human trafficking, domestic violence, and child abuse. As physicians are generally well respected in many societies, Kathy would be influential in connecting Laxmi with groups that may help to set her free.

Advocacy and Activism: Training in Medical School

It is likely that Kathy has not received any formal [training in health activism](#), since few medical schools or residency programs have advocacy electives [15]. As there is no prescribed form of activism that is applicable to every situation, I urge that medical schools should teach their students to denounce everyday violence, inequality, and injustice, and take action to reduce health care disparities and advocate for impoverished populations. Students need to learn in their clinical practice that their professional duties extend to protecting vulnerable people [3], particularly when patients' medical and social suffering is entwined. In addition, medical schools need to motivate their students' commitment to take action for [social justice](#) and to become powerful agents of change. These aims can be achieved through course development, case studies, community engagement, critical reflection, problem-solving skills, volunteer opportunities, and firsthand training, particularly in cross-cultural settings [6]. For example, if Kathy had received training on how to serve impoverished populations, intervene in their sociomedical realities, act collectively, build collaborations and coalitions with relevant groups, and participate in taking action for social change—particularly in international settings—she would have the knowledge and skills to better protect Laxmi's health and well-being.

Although some training in cross-cultural awareness and communication is often offered as part of health professionals' training, addressing horrendous health disparities in our

world today is complex and can be hard to integrate into health profession curricula. These disparities are caused by multiple forms of structural violence, including slavery, racism, sexism, gender inequality, poverty, war, and political violence [16]. Most clinicians are well aware that social factors deeply affect health, but they are not always trained to address these pressing social factors when treating patients, as Farmer notes [17]. For this reason, he and others ask: Should cultural competency training be replaced by “structural competency” training [16, 17]? Or do we need to offer training in navigating both structural inequality and cross-cultural complexities of global and international health encounters? Either way, clinicians need to study the social and cultural origins of poor clinical outcomes and learn how to promote health equity and social justice, a skill set that should be included in health professionals’ training.

Conclusion

Kathy alone cannot put an end to the local practice of kamlari during her brief visit to Nepal, but she can make a profound difference in Laxmi’s life by serving as her advocate. By collaborating with Nepalese colleagues and NGO actors, for example, Kathy might also help to rescue other kamlari girls and free them from abuse. In this way, Kathy can model how physicians can treat the sick, reduce their suffering, and speak out against injustice to them.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

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ETHICS CASE

Physician Encounters with Human Trafficking: Legal Consequences and Ethical Considerations

Commentary by Jonathan Todres, JD

Abstract

There is growing recognition and evidence that health care professionals regularly encounter—though they may not identify—victims of human trafficking in a variety of health care settings. Identifying and responding appropriately to trafficking victims or survivors requires not only training in trauma-informed care but also consideration of the legal and ethical issues that arise when serving this vulnerable population. This essay examines three areas of law that are relevant to this case scenario: criminal law, with a focus on conspiracy; service provider regulations, with a focus on mandatory reporting laws; and human rights law. In addition to imposing a legal mandate, the law can inform ethical considerations about how health care professionals should respond to human trafficking.

Case

Dr. W is an obstetrician working at a women's health clinic in a state that has a high prevalence of human trafficking. A couple arrives at her office, requests a private consultation, and asks whether she keeps information confidential. She assures them that she follows all state and federal laws and regulations regarding the management of protected health information.

The couple informs Dr. W that they "employ and manage" several young women as sex workers. They ask if the clinic would be able to screen their employees for sexually transmitted infections (STIs). They clarify that all services will be compensated; however, they request that no health records be kept for the women. They state that this is necessary to assure the women that they will not be at risk of being arrested because of the nature of their work.

Dr. W feels wary about providing STI testing and managing care for this small group of patients outside of her clinic's standard operating procedure. Dr. W understands that, legally, she is required to maintain health records for all patients, but she is also concerned that this particular underserved and vulnerable group of young women would never receive appropriate gynecological care if their employers find out she keeps

records for them. The couple promise to facilitate the patients' compliance with STI treatments, if necessary. Dr. W feels torn: she wants to give the women the best care possible while also protecting the community from the possible spread of STIs. But she also worries that, by agreeing to terms set by the couple who employs and manages these women (who might be trafficked and some of whom might be minors), she might be complicit in their exploitation.

Commentary

There is growing recognition and evidence that health care professionals regularly encounter—though they may not identify—human trafficking victims in various health care settings [1]. Identifying and responding appropriately to trafficking survivors requires not only appropriate clinical training but also consideration of the legal and ethical issues that arise when serving this vulnerable population. This essay examines three legal areas relevant to this discussion: criminal law, with a focus on conspiracy; service provider regulations, with a focus on mandatory reporting laws; and human rights law. In addition to imposing a legal mandate, the law in these areas can inform health care professionals' ethical considerations in responding to human trafficking during clinical encounters, at an institutional level, and as a profession.

Conspiracy Law and Health Care for Sex Trafficking Victims

Although it might seem strange to raise the specter of conspiracy charges with regard to a well-intentioned physician, an analysis of conspiracy law can illuminate some of the ethical issues in this case. Criminal conspiracy has four elements: an objective, a plan showing the means to accomplish that objective, an agreement between two or more people to cooperate to achieve that objective, and an overt act in furtherance of the crime [2]. Here, the couple who operates a prostitution business has set out the plan, and an act in furtherance of the crime—whether it is sex trafficking or a related charge such as pimping (living off the proceeds of the prostitution of another person) [3] or pandering (recruiting and retaining a person in prostitution) [4]—appears imminent. The critical question, from a legal perspective, is whether Dr. W and the couple have entered into an agreement to achieve the criminal objective.

To determine whether a person has agreed to conspire to commit a crime, the law asks whether: (1) she knows of the crime and (2) either (a) she intends to participate, (b) the crime is very harmful, or (c) she has a "stake" in the crime [5].

For the first element, given what the couple has conveyed to Dr. W—that they run a prostitution ring—she could not plausibly deny knowledge of a crime. [Prostitution](#) is illegal, as are operating a prostitution business and sex trafficking [3, 4, 6, 7]. If minors are among those individuals "employed" by the couple, the couple would be running a child sex trafficking ring—they are engaged in recruiting, harboring, and maintaining individuals to engage in commercial sex acts (when a child is the victim, a prosecutor

does not need to show force, fraud, or coercion was used by the defendant, as the consent of a minor is irrelevant for the crime of sex trafficking) [7]. If the couple uses force, fraud, or coercion to keep adults in their control, they likely are engaged in sex trafficking of the adult women as well.

Next, although it may be fair to conclude that the doctor does not intend to participate in the crime of sex trafficking, or have the purpose that the crime occur, the other two options for the second element put the physician's actions in more doubt. Courts have stated that "when a serious crime is involved, a supplier of goods or services may be 'held liable [for conspiracy] as a participant on the basis of knowledge alone,' even if 'it cannot reasonably be said that the supplier has a stake in the venture or has acquired a special interest in the enterprise'" [8, 9]. For example, a California appellate court stated that the operator of a telephone answering service might be able to be charged with conspiracy in an extortion, narcotics distribution, or counterfeit money scheme based on his knowledge that the telephone service was being used to facilitate one of these crimes, even if he did not intend to participate in the crime [10].

Human trafficking seems to be an obvious example of a crime that is very harmful. The harm inflicted on its victims can be life threatening [11]. Even if a court would be reluctant to convict a defendant (e.g., physician) on knowledge alone based on the crime's severity, the question remains whether the physician in this case has a "stake" in the enterprise. That element can be met when (1) the defendant charges the criminals (here, the couple) inflated rates, (2) the goods or services have no legitimate use, or (3) there is no legitimate use for the volume of goods supplied [9]. If Dr. W is paid more than her usual rates, she would have a stake in the enterprise. If she charges her usual rates, the case against her is not as strong. It might depend in part on whether she is paid "under the table." If she agrees to keep no patient records, for example, she might not record the payments. Proceeds received "off the books" might arguably give Dr. W a stake in the enterprise.

There are legitimate concerns about prosecuting a physician for conspiracy in a case like this one. Unlike cases involving telephone operators and others whose involvement may be more clearly motivated by profit, the physician aims to provide needed care. Equally important is what a successful prosecution might mean in terms of implications for clinicians' practice. What would physicians be required to inquire about—from a legal and ethical standpoint—beyond what is necessary to treat a patient from a clinical standpoint? Could a threat of conspiracy charges have a chilling effect on patient-physician communications? And, relevant to this case, would physicians be reluctant to treat certain [vulnerable populations](#) out of fear that doing so might inadvertently involve them in a criminal conspiracy? Ultimately, these questions and their broader policy implications weigh against the view that a physician such as Dr. W should be charged with conspiracy to commit sex trafficking or related crimes, unless there is clear evidence

that the physician is charging excessive rates and has little interest in helping these patients.

Although it might not be appropriate to proceed with conspiracy charges against Dr. W, it could be argued that, by providing care, Dr. W would be helping the couple to continue using these women and girls in their prostitution business. Therefore, examining the case through a conspiracy law lens highlights a critical ethical question: Should the physician's participation in this endeavor be viewed as enabling the exploitation of these women and girls?

Clinicians' Duty to Report Suspected Sex Trafficking or Sexual Exploitation of Minors

If any of the young women controlled by the couple are minors, Dr. W might have a legal duty to report these cases. All fifty states have mandatory reporting laws for child maltreatment [12, 13]. Health care professionals typically are deemed mandatory reporters and must report suspected abuse and neglect of children (under mandatory reporting laws, physicians or the hospital typically must report the case to child protective services, law enforcement, or both) [13]. In the past several years, some states have expanded their [mandatory reporting laws](#) to cover human trafficking (as of December 2015, 14 states had included sex trafficking as reportable acts, and ten of those also included labor trafficking) [13]. If a physician practiced medicine in one of those states and an underage girl who was part of this scheme presented with symptoms that suggest she might be a sex trafficking victim, the physician would be violating the law by failing to report this case. However, states that have not expressly included sex trafficking in their mandatory child abuse reporting laws still include "sexual abuse" and/or "sexual exploitation" as reportable maltreatment [13]. Because symptoms of sexual abuse, sexual exploitation, and sex trafficking can overlap, it would be difficult for a physician to argue that a patient shows signs of being a victim of sex trafficking, but not sexual exploitation or sexual abuse. A physician's recognition of sexual abuse symptoms or similar harms that are possibly the result of sex trafficking should trigger his or her reporting of the case. Said another way, if, based on his or her examination of a patient, a physician suspects a child has been subjected to sexual abuse, it would be a troubling result if we allowed the physician to not report solely because the physician suspects that the abuse occurred in the context of money or food being exchanged for sex.

The physician's duty to report if she suspects that a minor is being sexually abused or trafficked is supported by the purpose of mandatory reporting laws, which is to spur intervention in appropriate cases to prevent further harm to children. If a physician continues to provide health care services while remaining silent about the continued sexual exploitation of a child, her actions would fail to achieve the goal of reducing harm to children.

Research shows that some health care professionals do not report all suspected cases of child maltreatment [1]. Reasons for not reporting include concerns that a report will not help the child or family, may result in further harm, or could chill future communication between patient and physician [1]. Clinicians' concerns about mandatory reporting laws must be taken seriously, particularly because in many settings, social service agencies may not have the capacity to handle additional cases or might lack specialized training to serve child trafficking survivors [1]. To be clear, however, the legal and ethical obligation of health care professionals in these scenarios is to seek help for the child, not to return her to her abusers. The response to physicians' concerns about mandatory reporting laws must be to address them at a policy level by strengthening social service agencies' capacities to help at-risk and exploited children rather than to allow clinicians and others who work with children to decide for themselves on a case-by-case basis whether and when to comply with the law.

Health Care Professionals' Obligations under Human Rights Law

Human rights law is also relevant in this context, even if its legal authority in the United States is more limited (although the United States has supported the development of human rights treaties historically, it has been slow to ratify them once they are adopted) [14]. There is no question that human rights law prohibits human trafficking [15, 16]. For example, in the Rome Statute of the International Criminal Court, the definition of a "crime against humanity" includes "enslavement" which itself is defined as including "trafficking in persons, in particular women and children" [17]. Beyond treaty law, given that slavery violates customary international law [18], there is an argument that human trafficking—the experience of which is akin to enslavement for many victims—is also prohibited under customary international law, meaning that prohibition applies to every country, regardless of whether it has ratified an applicable treaty.

Physician facilitation of human rights violations has long been debated in other contexts, most notably with interrogation of prisoners of war or enemy combatants [19]. Should physicians participate in actions that might rise to the level of torture? Are they ensuring patients' survival and well-being or merely enabling harm? A similar question could be asked here: Should a physician participate in—and accept compensation for aiding—a scheme that involves the sexual exploitation of young women and girls? The answer must be no. The desire to assist vulnerable patients is understandable, as is the concern that the patients' situation might become worse if the physician refuses to offer care. But there are other options in this scenario, not least of which is that the physician can ensure the couple is reported to law enforcement so police can investigate.

Conclusion

Evaluating Dr. W's dilemma using a conspiracy law framework highlights the idea that her participation, while perhaps well-meaning, may actually facilitate exploitation. Mandatory reporting laws indicate that Dr. W has a duty to report any minors

“employed” by the couple. Finally, human rights law reminds us of every person’s duty not to participate in human rights violations, however well-intentioned we might think our actions are. Ultimately, the ethical challenges raised by this case, combined with the growing recognition that many health care professionals encounter human trafficking [20], should prompt the medical profession to develop guidelines for responding to all forms of human trafficking. Requiring relevant health care professionals to be trained in identifying and treating trafficking survivors would not only help reduce and perhaps even avoid harm, but also strengthen the broader responses to human trafficking. A multisector response is needed to prevent, identify, and respond effectively to human trafficking, and health care professionals like Dr. W have critical roles to play.

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ETHICS CASE

Human Trafficking, Mental Illness, and Addiction: Avoiding Diagnostic Overshadowing

Commentary by Hanni Stoklosa, MD, MPH, Marti MacGibbon, CADC-II, ACRPS, and Joseph Stoklosa, MD

Abstract

This article reviews an emergency department-based clinical vignette of a trafficked patient with co-occurring pregnancy-related, mental health, and substance use disorder issues. The authors, including a survivor of human trafficking, draw on their backgrounds in addiction care, human trafficking, emergency medicine, and psychiatry to review the literature on relevant general health and mental health consequences of trafficking and propose an approach to the clinical complexities this case presents. In their discussion, the authors explicate the deleterious role of implicit bias and diagnostic overshadowing in trafficked patients with co-occurring addiction and mental illness. Finally, the authors propose a trauma-informed, multidisciplinary response to potentially trafficked patients.

Case

Dr. Shah, an emergency department (ED) resident in New York City, entered the room of a young pregnant patient who was bleeding and visibly frightened. The patient, who only spoke Spanish, was accompanied by her brother, who translated. He explained that the patient suffered from schizophrenia and had been refusing her medications for the last couple of weeks. He added that she'd had a few episodes of aggressive behavior, directed at others and herself. While the patient's brother was talking, Dr. Shah noticed a few bruises and puncture marks with associated ecchymosis (subcutaneous bleeding similar to a bruise) on the patient's arm. The brother saw that Dr. Shah had noticed these marks and explained that the patient sells herself for drugs.

Dr. Shah began to suspect that the patient's brother might not be trustworthy, so she requested a certified clinical interpreter. Through the interpreter, the patient conveyed that she was miscarrying and asserted that she does not have schizophrenia, although she admitted feeling depressed sometimes. The patient's tone became increasingly desperate and she explained, through the interpreter, that the man claiming to be her brother was holding her captive. She stated she was brought to the US as his fiancée,

and, upon arrival, he confiscated her passport, forced her to have sex with him, and introduced her to drugs.

At this point, the man explained that his sister had long had delusions of persecution. He also disclosed that she had required temporary restraints the day before after threatening family members while she was high. He suggested that perhaps this episode had fueled the current delusion.

Dr. Shah had recently read about a case in which a 14-year-old girl had been to the emergency department for treatment and had told the staff she was being sex trafficked. The man accompanying the girl had also claimed she had schizophrenia. The clinicians believed the man and discharged the girl to his care; he was later found to be trafficking girls into commercial sex. The girl was not rescued until police found her bound in a closet during a drug raid weeks later.

Dr. Shah wondered what to do.

Commentary

The clinical scenario described above might seem far-fetched or extreme. However, Dr. Shah's dilemma mirrors many human trafficking clinical encounters in which patients present with medical, mental health, and substance use disorder needs. The health needs of this patient might very well suggest that she is being trafficked and should not be dismissed merely because the "brother" has identified the patient as having a mental illness or substance use disorder. This paper will discuss the implications of the patient's presenting symptoms, the role of implicit bias and diagnostic overshadowing in trafficked patients with co-occurring addiction and mental illness, and the importance of providing trauma-informed care to patients who could be trafficking victims.

Terminology

The article authors define human trafficking according to United States law. Federal law defines "severe forms of trafficking in persons" as:

- (A) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
- (B) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery [1].

Note that trafficking does not necessarily involve movement and does not necessarily involve physical captivity. Vulnerable people are lured and trapped via myriad means

including economic abuse, psychological coercion, threats against family, drug addiction, physical abuse, and sexual abuse [2]. Vulnerability to trafficking exists on societal, community, and individual levels, and might be a result of society's demand for cheap goods, disruption of a community through humanitarian crisis, or childhood sexual abuse [3].

The authors also specifically use the term "survivor" to refer to those who currently are or previously have been trafficked. "Survivor" is used rather than "victim," as it is an empowering term that has been embraced by anti-trafficking organizations [4-6] to capture the strength it takes to face extensive trauma.

Health Implications of Being Trafficked

Physical consequences of being trafficked include a range of health problems resulting from occupational, trauma, and living condition-related risk exposures [7].

Pregnancy complications. One category of medical sequelae of being trafficked is pregnancy-related complications. Pregnancy resulting from sexual assault during labor or sex trafficking can be used as a means to coerce a trafficked female, keeping her emotionally bound to her trafficker and further reliant on the trafficker to meet her own and her child's needs [8]. In a survey of sex trafficking survivors in the United States, 71.2 percent of 66 respondents reported at least one unwanted pregnancy during the period of their exploitation, and 21.2 percent reported five or more pregnancies [9]. The same survey found that 55.2 percent of the 67 female survivors reported at least one abortion, and 29.9 percent reported multiple abortions, with half of those who had had an abortion indicating that they were forced to have at least one of the abortions [9]. Similarly, 54.7 percent of 64 respondents reported at least one miscarriage and 29.7 percent had more than one miscarriage. In addition to enduring abortions and miscarriages with little, if any, clinical attention, trafficking survivors might not have adequate access to prenatal health care and can suffer from pregnancy-complicating sexually transmitted infections, such as HIV [8, 10]. Not surprisingly, a study from the United Kingdom showed that the health professional group most likely to encounter trafficked persons is maternity services professionals [11]. And a US-based study of trafficked persons found that approximately one quarter of labor and sex trafficked persons reported that they saw obstetricians during their period of exploitation [12]. So, the patient in this case presenting as pregnant and miscarrying should be regarded as a warning sign for Dr. Shah and as an opportunity for her to intervene.

Addiction. The patient in this scenario has physical stigmata of intravenous drug use in the form of track marks. [Addiction](#) has a complex relationship with human trafficking: it can exacerbate a trafficked person's vulnerability, be part of a captor's means of coercing a captive person to submit, be part of a captor's means of incentivizing a captive person to remain captive, and be used by the captive person as a mechanism of coping with the

physical and mental traumas of being trafficked [9, 13]. The first explanation appears to be the most common, although research is limited. For example, an anti-trafficking service provider in Maine found that 66 percent of its clients reported that substance use led to their being trafficked while only 4.5 percent reported that it arose after their being trafficked [13]. A broader survey of US survivors of sex trafficking found that 84.3 percent used substances during their trafficking exploitation. Alcohol, marijuana, and cocaine were each used by more than 50 percent of respondents and nearly a quarter (22.3 percent) used heroin [9].

Opioids in particular are an effective coercion tool for traffickers because they numb both emotional and physical pain; clinicians have noted clear links between the current US opioid epidemic and trafficking [14]. Some traffickers recruit directly from substance use disorder treatment facilities [15]. Moreover, high rates of opioid-overdose death underscore the potentially lethal consequences of an opioid addiction for trafficked persons [16]. Therefore, as in this case, [opioid addiction](#) in and of itself may be a red flag for clinicians to screen for trafficking.

The power of addiction in trafficking has been recognized by the criminal justice system as well. In 2014, a man in Florida was convicted of sex trafficking based on his use of drug addiction to coerce his victims [17]. One of the survivors he exploited was quoted as saying, “He made me believe that he cared and that he loved me and he was going help get me off the streets.... Instead he got me addicted.... [The drugs] were all bought illegally for the purpose of addicting me and controlling me” [17]. Given the well-documented nature of addiction’s links to trafficking, in our case example, even if the “brother” is telling the truth about the patient’s substance use problem, it should be yet another component of a physician’s index of suspicion that the patient is trafficked.

Mental health. The “brother” in this scenario claims that the patient is suffering from delusions, possibly as a result of schizophrenia or her drug use. While labeling the patient delusional could be a ploy to undermine her agency and negate the veracity of her claims, clinicians should be aware that mental illness can be an indicator that a patient is being trafficked and should raise a clinician’s index of suspicion that she’s being exploited. Studies have shown that people with a known major mental illness like schizophrenia are more likely to be victimized physically than those without mental illness [18]. Moreover, intense, complex trauma—such as could develop in a person who is trafficked—is strongly associated with a patient’s development of psychosis, including [schizophrenia](#) [19, 20]. Not surprisingly, 15 percent of trafficked persons in contact with mental health services in South London between 2006 and 2012 met criteria for schizophrenia and related disorders in the *International Statistical Classification of Diseases and Related Health Problems* [21]. Trafficked persons with psychotic disorders and experiences of violence prior to being trafficked are likely to require more therapeutic support than patients with nonpsychotic disorders or those suffering from psychological distress [22]. Research

conducted in many countries demonstrates that, in addition to psychosis, survivors of labor and sex trafficking experience high rates of depression, anxiety, and posttraumatic stress disorder (PTSD), self-harm, and attempted suicide [23-25].

Responding to a Potentially Trafficked Person with Mental Illness and Addiction

Trauma-informed approach to care. Any patient encounter involves obtaining and analyzing subjective and objective data with varying degrees of uncertainty and using this information to formulate a care plan. However, in cases of potential human trafficking, like this one, the stakes are particularly high, underlining the need for a protocol, and a multidisciplinary approach that is survivor-centered, culturally relevant, evidence-based, gender-sensitive, and [trauma-informed](#) [26]. A summary of recommendations for how to approach potentially trafficked patients, compiled from survivors and international experts, is outlined in the table below. Protocols for identifying, assessing, and caring for trafficked persons can also be found on the HEAL Trafficking website [27]; these models can be adapted to particular practice settings, as exemplified by the National Human Trafficking Resource Center’s “Framework for a Human Trafficking Protocol in Healthcare Settings” [28]. Health care professionals should familiarize themselves with state-specific mandatory reporting requirements. The overarching goal of the clinical encounter is not rescue but rather improving health and safety. It is important to respect all patients’ assessment of their situation and risks to their safety. The core components of the general approach to a potentially trafficked patient include meeting basic needs, building trust and rapport, being conscious of language, remaining sensitive to power dynamics, and avoiding retraumatization [29, 30]. The patient should be interviewed alone, with an interpreter as needed.

Table 1. Expert and survivor-informed tenets: caring for a trafficked person [29, 30]

General approach
Do no harm. Remember that the goal is not rescue, but improving health and safety. Prioritize the safety of trafficked persons, yourself, and other staff. Provide respectful, equitable, non-discriminatory care. Approach interactions with the victim or survivor with respect and kindness. Be empathetic, but not sympathetic, or appearing to pity. Recognize that the victim is a human being that has been abused, exploited, and traumatized far beyond what most people can imagine. Be aware of nonverbal communication: do not show shock or disgust. Be nonjudgmental. Know the basics of the patient’s cultural and religious background in

<p>order to understand his/ her worldview and to avoid potential offenses.</p> <p>Use same-sex staff when possible.</p> <p>Provide a private, warm, quiet, and comfortable place for the interview and exam.</p>
<p>History-taking</p>
<p>Interview the patient alone.</p> <p>Adequately select and prepare interpreters and co-workers.</p> <p>Sit, don't stand or hover. Take your time, don't multitask; avoid writing while the patient is talking.</p> <p>Avoid asking the same question more than once, which may cause frustration or distrust on the part of the patient.</p> <p>Communicate effectively with other members of the care team to avoid repeated interviews with the victim, which may result in retraumatization.</p> <p>Listen to and respect each patient's assessment of their situation and risks to their safety.</p>
<p>Physical exam</p>
<p>Allow the patient to lead or set the pace of the exam.</p> <p>Provide assurance that he/she is in control of the exam.</p> <p>Ask permission each time you touch the patient.</p> <p>Explain exactly what you are going to do.</p> <p>If it is going to hurt, say it is going to hurt.</p> <p>Be gentle, but don't "sugar coat."</p>
<p>Response</p>
<p>Collaborate with multidisciplinary health care team to formulate plan; include patient advocate and social worker where possible.</p> <p>Provide information in a way that is understood.</p> <p>Obtain informed consent before sharing information about patients or beginning procedures to diagnose, treat, or make referrals.</p> <p>Be prepared with referral information and contact details for trusted individuals and organizations that can provide support.</p> <p>Never promise more than you can deliver.</p> <p>Ensure the confidentiality and privacy of trafficked persons and their families.</p> <p>Respect the rights, choices, and dignity of each person by encouraging independent decision making.</p> <p>Include the patient in conversations about him/her when present.</p>

In particular, it is critical to approach all patients with a trauma-informed care perspective [26], which prioritizes a safe environment for the clinical encounter, helping the patient to regain a sense of agency and autonomy during the clinical encounter. Victims of interpersonal violence, including violence stemming from human trafficking, can experience sexual, physical, verbal, or psychological assault on a daily or even hourly basis. Any or all of these ongoing traumas, combined with social stigma, can result in the exploited person feeling less than, or other than, human. In the experience of one of the authors (MM), those who live with the stigma and pain of a diagnosis and experience mental illness and/or addiction can also have feelings of extreme social degradation. A trauma-informed approach to care enables clinicians to recognize that many patients have experienced abuse in their past, that many routine aspects of providing health care—such as asking a patient to undress or performing a gynecological exam—might be unintentionally retraumatizing, and that structural and personnel level changes might be needed. When a health care professional interacts with a potentially trafficked patient in a nonjudgmental manner and treats that patient with human dignity by asking permission before examining patients and reassuring them that they are in control of the exam, these actions alone can be interventions. Trauma-informed care is an approach that entire health systems should adopt for all patients. Training all staff, including receptionists and security staff on trauma-informed principles; not requiring patients to tell their clinical story multiple times during a clinical visit; and providing multidisciplinary, team-based care for survivors of interpersonal violence are all possible systems-level changes that may improve care for trafficking survivors [31].

Mental illness and addiction. An especially challenging component of this clinical vignette is the possibility that the trafficking exploitation reported by the young woman could be a delusion rather than reality. Mental health clinicians have expressed that it is often difficult to obtain histories from trafficking survivors [32]. To further obfuscate the clinical picture, patients with psychoses who have been sexually abused or bullied can have hallucinations in which the actual content or the themes of content is similar to that of their trauma, making it difficult to separate the two [33].

In approaching patients with co-occurring addiction and mental illness, clinicians must be particularly aware of their own biases and potential “diagnostic overshadowing” [34]. Diagnostic overshadowing refers to a well-described clinically and ethically problematic phenomenon in which clinicians ignore patients’ general health concerns because of that patient’s mental illness [35–38]. At the core of diagnostic overshadowing is a clinical reasoning error; that is, some clinicians unconsciously tend to express negative bias when diagnosing patients who have co-occurring mental health and general health problems, such that legitimate general health problems are misattributed as originating from a patient’s mental illness [36]. For example, a clinician might assume the patient

with schizophrenia complaining of chest pain is just “crazy” or anxious, rather than accounting for a higher risk for heart disease among those with schizophrenia [36, 39].

Clinicians should be particularly vigilant to avoid diagnostic overshadowing, given that persons with chronic mental illness are not only at increased risk for all forms of interpersonal violence [18], but also more likely to suffer subsequent ill general health and to disclose the violence exclusively to health professionals [34, 40]. It is important to maintain a high index of suspicion for true interpersonal violence or exploitation, thoughtfully evaluating each concern expressed by a patient, knowing that even delusions can have kernels of truth and important places in a patient’s story of what she or he has experienced. Also, just because a patient has a known delusion, clinicians should not assume that the patient’s other concerns are not valid or do not deserve their attention.

Conclusion

Because each interaction with a potentially trafficked person is complex and critical, health systems should have trauma-informed interpersonal violence protocols in place that involve a multidisciplinary response team and respond to the critical needs of trafficking survivors. Dr. Shah should be mindful of the sway of implicit bias and diagnostic overshadowing, applying core principles in response to trafficking coupled with the use of a multidisciplinary team in her encounter with this woman and her “brother.” A response team should include social workers, emergency clinicians, behavioral health professionals, substance use disorder specialists, and obstetrics and gynecology colleagues [29, 41, 42].

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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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THE CODE SAYS

The AMA *Code of Medical Ethics*' Opinions Related to Human Trafficking

Danielle Hahn Chaet, MSB

The American Medical Association has a policy (H-65.966, "Physicians Response to Victims of Human Trafficking") that specifically encourages its member groups to raise awareness about human trafficking. The policy states that "physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims" [1]. Although the *Code of Medical Ethics* does not explicitly address human trafficking, it addresses violent harm to patients more broadly.

Specifically, Opinion 8.10, "Preventing, Identifying and Treating Violence and Abuse," states that "physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse" [2]. Outlined in this opinion is the physician's obligation to familiarize him- or herself with strategies for violence and abuse detection, resources available to the patient, and legal [requirements for reporting](#). The opinion further states that physicians should "obtain the patient's informed consent when reporting is not required by law." In the case of minors, reporting to an appropriate agency, with or without the consent of the child, is required by law in all 50 states [3]. When the patient is an adult, however, physicians should inform the patient about his or her legal requirements to report any suspected violence or abuse and should obtain the adult patient's informed consent to do so [2]. Exceptions are appropriate when a physician believes that an adult patient's refusal to authorize reporting is coerced. As always, physicians should protect adult patient privacy when reporting by disclosing only the minimum necessary information. This information might vary depending on what applicable laws or policies are valid where the physician is practicing. (See also Opinion 3.2.1, "Confidentiality" [4].)

Opinion 2.2.2, "Confidential Health Care for Minors," has limited applicability to human trafficking as the framework of the opinion assumes that a lawful parent or guardian is involved in the life of the child. However, some guidance may be useful to physicians who are caring for [minor patients](#) whom they believe might be victims of trafficking. The opinion states that "In some jurisdictions, the law permits minors ... to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness." It also states that "Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state" [5].

Physicians in these jurisdictions should be aware of applicable laws and possible exceptions to them.

In all circumstances, physicians should follow state, federal, and institutional reporting guidelines when trafficking or any other violence or abuse is suspected.

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STATE OF THE ART AND SCIENCE

Ethical Considerations in Mandatory Disclosure of Data Acquired While Caring for Human Trafficking Survivors

Patrick L. Kerr, PhD, and Rachel Dash, ACSW, MSW

Abstract

Accurate data on the prevalence and psychological effects of human trafficking as well as treatment outcomes for survivors are essential for measuring the impact of interventions and generating better understanding of this phenomenon. However, such data are difficult to obtain. A legal mandate for health care professionals to report trafficking opens opportunities for advancing our work in the field of human trafficking but also poses risks to survivors seeking services. In this article, we provide an analysis of some critical ethical considerations for the development and implementation of a mandatory reporting policy and offer recommendations for the ethical implementation of such a policy.

Introduction

Human trafficking ("trafficking"), or slavery, is defined as sexual labor (e.g., prostitution, stripping, performing pornography) or nonsexual labor (e.g., agricultural, fishery, factory, or construction work) induced via force, fraud, or coercion [1]. Awareness of this phenomenon has increased over the past two decades, and it is increasingly being recognized as a significant global problem requiring comprehensive intervention [2]. The causes and effects of human trafficking are complex and are characterized by intersecting social, psychological, cultural, and political factors [3].

One primary challenge for anti-trafficking initiatives is obtaining accurate data on the prevalence and impact of trafficking. Even the best current estimates are impeded by limited information sources [3-5]. Estimates of the number of people living in slavery range from 4 million to 27 million [6, 7]; according to the most widely cited estimate, 20.9 million people are enslaved today [4]. Using law enforcement data, the US Department of State identified 369,083 trafficking victims worldwide between 2008 and 2015 [5], which is clearly inconsistent with the above estimates. The lack of accurate data is problematic because it prevents a clear understanding of the prevalence of human trafficking and its impact, thus impeding efficacious interventions. The lack of accurate data is attributable to a combination of factors: the illicit nature of trafficking, the lack of data comparability between countries due to differing data collection

systems, bias due to divergent understandings of reporting requirements, and differences in data collectors' definitions of human trafficking [8, 9]. In the US, a potential option for overcoming these barriers is health care professionals' [mandatory reporting](#) of suspected trafficking to governmental health and human service departments. Mandated reporting by health care professionals is required nationwide under some circumstances [10]; for child victims of trafficking, it would fall under child abuse reporting requirements [11].

Mandatory Reporting of Human Trafficking in Health Care Settings

Required disclosure of information about trafficked persons, including their health status and their health care needs, would follow the same line of reasoning as mandated [reporting for infectious diseases](#). Like public health strategies for infectious disease, ending trafficking requires a multifaceted approach that identifies people being trafficked and responds to their health care and psychosocial needs. This approach should be legally distinct from mandated reporting laws aimed at preventing harm to vulnerable populations (e.g., for child abuse or neglect) but could still facilitate intervention in trafficking cases. In both circumstances, mandated reporting may precipitate intervention and prevent further harm.

Mandated reporting legislation for trafficking is nascent. As of 2016, 13 states have mandated reporting laws for trafficking that are distinct from child abuse or neglect reporting requirements [12]. Yet all but one state statute applies to children only; the exception is Illinois, which extends reporting requirements to youth ages 18-22 in state-run facilities [12]. As the health effects of trafficking and the health care needs of trafficking victims and survivors become better understood, health care professionals' role in identifying trafficking and responding to the needs of adult and youth survivors has become clear [13-16]. If mandatory reporting laws for trafficking are in place with uniform data reporting requirements and a single, unified data collection system is established, health care settings may serve as a useful forum to document the actual volume of trafficking and its impact on survivors. However, calculating the prevalence of trafficking and its health effects from mandated reports would likely be limited in that the number of unreported trafficking cases, like the number of child abuse cases, can only be estimated.

Public Health Surveillance as a Response to Human Trafficking

In the twenty-first century, the concept of public health problems has expanded from infectious diseases to include a multitude of social and psychosocial causes of poor health and death like smoking, suicide, and violence [17, 18]. Trafficking also constitutes a public health problem [19]. Todres [19, 20] has proposed a public health surveillance model that would facilitate better data collection on the incidence, prevalence, and associated social, psychological, and behavioral risk factors for being trafficked. Extrapolating from Todres's proposal, the rationale for this approach is twofold: (1)

trafficking adversely affects the health of survivors and their communities and (2) trafficking cannot be addressed as either a health or societal problem through legislative and law enforcement avenues alone.

Public health surveillance for trafficking could be modeled on public health surveillance for infectious diseases, which involves monitoring the health of the population and identifying risks for outbreaks of infection using a case-based or statistical approach [21]. Case-based surveillance focuses on the individual level and is most effective in preventing the spread of disease within a population [21]. However, the goal of intervention is commonly stymied by a lack of resources for follow-up on identified cases, concern that the disease carrier would be stigmatized if identified, and the specific infection course of the disease (i.e., latency period for symptoms relative to time of infection) [21]. Although this approach is well intentioned, its attendant privacy and confidentiality risks can outweigh the potential health benefits to the person or the population, especially when there is stigma associated with a disease or condition (e.g., HIV, hepatitis C) [21].

By contrast, statistical surveillance is a population-level surveillance methodology that facilitates disease monitoring with minimal risk of violations of patient privacy and confidentiality. One approach to statistical surveillance of disease combines data from death and birth certificates with epidemiological research. Another approach is the use of [disease registries](#), which collect de-identified data on types and outcomes of diseases or conditions. Cancer registries and state trauma registries have been effectively implemented to accurately but confidentially record courses of specific diseases in particular cases when they present in health care settings. The registry approach is thus an effective tool for generating accurate estimates of clinical disease epidemiology, with minimal risk to confidentiality and privacy [21].

These two public health surveillance methodologies can be applied to mandated reporting. In general, a registry appears to be preferable to a case-based investigational method because it affords better protection against breaches of confidentiality and requires fewer resources. However, the use of a registry system for reporting trafficking would likely require systemic changes to facilitate accurate and ethical data collection. By default, survivors have been victimized by gross violations of their basic human rights [22]. There are cogent reasons for their distrust of health care professionals beyond their experiences of victimization by traffickers. Well-intentioned responders sometimes inadvertently violate survivors' rights by "outing" or re-traumatizing them through interviews [22]. Mandated disclosure of information about excruciating experiences in slavery risks retraumatizing survivors [23]. Moreover, survivors are often lied to by traffickers about the harms of seeking help (e.g., they are told they will be shamed, arrested, deported). Thus, disclosure may reinforce victims' and survivors' [distrust](#) of health care professionals. Development of a reporting system that is sensitive and

responsive to the unique experiences of trafficking victims and survivors will be essential, and survivors will have a critical role to play in shaping that system.

Benefits and Risks of Mandated Reporting of Human Trafficking by Health Care Professionals

It is important to note that there is already a system in place for reporting suspicions of trafficking to the National Human Trafficking Resource Center using the national hotline, which victims may also call or text to receive help [24]. Information from these calls is submitted to law enforcement agencies, which then investigate the situations reported. In contrast, the issue addressed here pertains to reporting by health care professionals of confirmed (to the extent possible) cases of trafficking encountered during the provision of health care services.

Benefits to population. There are two primary advantages to mandated reporting of trafficking by health care professionals. First, knowing that trafficking is increasing or decreasing in certain regions or during certain time periods may illuminate causal factors that could then be targeted by intervention and prevention efforts. Second, accurate data could inform policy decisions regarding fiscal appropriations for survivors' health care service needs and anti-trafficking initiatives. Funding for anti-trafficking work could benefit from accurate data that might help funnel resources to areas with the greatest need [25–27].

Risks to individuals. There are multiple risks to trafficking victims and survivors from mandated reporting of trafficking by health care professionals. First, trafficking victims and survivors may not understand the consequences of reporting. For mandated reporting guidelines to be implemented ethically, consent forms to receive health care services would need to incorporate statements about mandatory reporting of human trafficking—whether suspected or confirmed. This would necessitate consideration of the coercive nature of trafficking and the wide variability in trafficking survivors' backgrounds as well as their potential distrust of clinicians. Trafficking victims' and survivors' English proficiency, literacy, emotional state, history of coercion, comprehension of rights, ability to understand limits of confidentiality, and familiarity with how trafficking is defined can all inhibit effective communication with health care professionals and limit their ability to understand the limits of confidentiality with respect to their experiences in trafficking. For example, most survivors do not self-identify as being trafficked. Some may see themselves as a willing participant in prostitution because their trafficker is their "boyfriend" (a common term for sex traffickers/pimps); others may not understand that their exploitation by a "boss" to whom they are "indebted" and who prevents them from leaving their worksite constitutes trafficking. The challenge of ensuring that informed consent procedures can be followed is tied to broader issues of ensuring survivors' trust and safety, which are

rooted in their experiences of physical threat, danger, loss of power over their lives, and disenfranchisement from decisions that affect their well-being [28].

Second, while protocols for maintaining the security of trafficking data could be implemented, security breaches of personal information are possible even with highly secure data [26]. The more places that health information resides, the more vulnerable the data becomes. This places survivors at risk for identification, which can increase the risk of retaliation by traffickers. Moreover, the mere existence of a system for mandated reporting may be misinterpreted by traffickers as posing a threat to their enterprise. This may deter traffickers from permitting victims to access health care or may induce them to seek retribution when survivors seek health care, thus further limiting opportunities to identify survivors and offer assistance.

Is Mandatory Reporting of Human Trafficking by Health Care Professionals Ethical?

In the US, protection of confidentiality of personal health information is codified in federal law [29]. Exceptions to these protections, such as disclosure for research, are also built into ethical guidelines and laws and are based on the principle of nonmaleficence. Provisions for exempting health information from confidentiality in specific circumstances ensure that the benefits of disclosure outweigh the risks [30]. In evaluating the potential risks and benefits of disclosure, the answer to the question of whether mandatory reporting of trafficking is ethical is “yes”; however, this must be cautiously qualified within a bioethics framework.

Beauchamp and Childress [31] have articulated four principles for ethical decision making regarding medical practice or research: (1) respect for autonomy, defined as a person’s capacity for autonomous/independent decision making; (2) nonmaleficence (“do no harm”); (3) beneficence (“do good” when ethical and feasible); and (4) justice, defined as the equitable distribution of benefits, risks, and costs. Through this bioethical lens, mandated reporting of trafficking must be contextualized. Respect for autonomy, the balance of good versus harm done, and distribution of justice would be situationally dependent. The priority in applying these principles to practice would be a risk/benefit analysis for the individual patient. Health care professionals must be given specific criteria to use in determining if reporting trafficking will pose undue risks to the individual patient to whom they are providing care. Criteria could include whether reporting unduly deprives the survivor of autonomy in the disclosure of health information, whether benefits of reporting this survivor’s information would outweigh the risks of doing so, and whether the potential harm prevented is equal to or greater than the potential harm done.

Conclusion

Future legislation or policies at the state or federal level regarding mandated reporting of trafficking by health care professionals must balance the importance of goals such as

increased accuracy of data with respect for the needs of the patient. In conclusion, we offer the following recommendations for the process of developing such policies:

1. Trafficking survivors must be part of development of such a policy.
2. Research on the potential short- and long-term impacts of mandated reporting on trafficking survivors must be conducted before proceeding with policy development.
3. Legislation for mandated reporting of trafficking must include funding for appropriate training of health care professionals in identification and reporting of trafficking and funding streams for publicly funded health care services for survivors.
4. Models of informed consent that meet the unique needs of diverse trafficking survivor populations must be implemented.
5. A trafficking registry with minimal identifying data should be the first choice considered among public health surveillance methodologies.

Human trafficking is a complex phenomenon, the nature and effects of which are just beginning to be fully understood. Mandated reporting of human trafficking presents both opportunities for better addressing this problem as well as risks. A thoughtful survivor-informed process for developing a system for mandated reporting will be necessary for balancing the needs and goals of all respective stakeholders, including survivors, health care professionals, policymakers, and the general public.

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POLICY FORUM

Mandatory Reporting of Human Trafficking: Potential Benefits and Risks of Harm

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Abstract

Human trafficking, including both sex and labor trafficking, has profound consequences for the safety, health, and well-being of victims and survivors. Efforts to address human trafficking through prevention, protection, and prosecution are growing but remain insufficient. Mandatory reporting has the potential to bring victims and survivors to the attention of social service and law enforcement agencies but may discourage trafficked persons from seeking help, thereby limiting the ability of health care professionals to establish trust and provide needed care. States' experience in implementing child abuse laws can be useful in assessing the potential risks and benefits of mandatory reporting of human trafficking.

Introduction

Human trafficking, which includes both sex and labor trafficking, has profound consequences for the health, safety, and well-being of victims and survivors [1-4]. Human trafficking has been defined as:

the recruitment, transportation, transfer, harbouring or receipt of persons by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs [5].

Public recognition of the scope and severity of human trafficking has grown since the late 1990s both globally and in the United States, while public and private sector responses—to deter and punish traffickers and assist trafficked persons with targeted and improved services—have increased [6, 7]. There is a pressing need for effective approaches to prevent trafficking, prosecute traffickers, and protect trafficked persons. From an ethical perspective, protection of trafficked persons involves both beneficence

(providing assistance or benefit) and nonmaleficence (avoiding harm). Ultimately, health care responses to the needs of trafficking victims and survivors, who are at risk for or have already suffered profound harm, must be guided by a key tenet of medical ethics: do no harm [8].

In assessing the contribution that health care professionals can make to broader anti-trafficking efforts, two recent developments are important to consider. First, responses to human trafficking are incorporating medical and public health perspectives to a greater degree than in the past [9]. Second, mandatory reporting of human trafficking by health care professionals is incorporated into the law in a growing number of jurisdictions in the United States [10, 11]. Health care professionals are already mandated reporters under existing laws that require reporting of child abuse, domestic violence, and physical injuries such as knife and gunshot wounds [10, 11]. Mandatory reporting laws generally are designed to identify and connect victims to protective services and to bring perpetrators to the attention of authorities [10]. Although requiring health care professionals to report human trafficking is intended to help trafficking victims, it may also create ethical dilemmas because mandatory reporting entails risks as well as benefits [1, 10–12]. This article explores these risks and benefits by examining the evolution and implications of the growing trend to include human trafficking in [child abuse reporting](#) laws.

Human Trafficking and Strategies for Its Prevention

Prevalence and health effects. The prevalence of human trafficking is not known, but it is estimated to affect millions of people globally [1, 7]. Trafficking victims and survivors are diverse in terms of age, income, gender, race, and other factors, although members of vulnerable groups are almost certainly at increased risk [1–4, 7]. In the US, for example, at-risk youth include those who have been sexually abused; youth who lack stable housing; sexual and gender minority youth; youth who have used or abused drugs and/or alcohol; and youth who have experienced homelessness, foster care placement, or juvenile justice involvement [1]. Trafficked children, adolescents, and adults experience adverse social, legal, and health consequences [1–4, 9–15]. Health consequences are both physical—sexual and reproductive health problems, injuries from physical abuse, and chronic medical conditions—and mental—posttraumatic stress disorder (PTSD), anxiety disorders, depression, substance use, suicidal ideation and attempts, and homicide risk [14]. For children and adolescents, the adverse social and developmental impacts of trafficking are of comparable significance to the physical and mental health effects [1].

A reporting system that could spare trafficking victims these consequences or connect them with services would be desirable. However, the development of such a system is complicated by many factors, including the fact that the terminology used to define and describe human trafficking is sometimes unclear or inconsistent and categories often

overlap, making it difficult to identify who should be reported and what services they need. For example, sexual exploitation and sex trafficking frequently are used interchangeably and without precision in research studies, service delivery programs, and governmental policies, even though they are not coextensive [1].

Responses to human trafficking. Initial responses to human trafficking over the past two or three decades in international protocols, US laws, and funding programs emphasized a criminal justice approach—prosecuting traffickers—over preventing trafficking and protecting trafficked persons [1]. Beginning in the late 1990s, prevention and protection have been increasingly prioritized alongside prosecution; there is also an increased recognition that diverse strategies implemented by multiple sectors—journalism and the media, human rights agencies and nongovernmental organizations (NGOs), social service and medical providers, the public health sector, and small businesses and large corporations—are essential complements to a law enforcement approach [1, 10]. In the past few years the medical and public health communities have become involved in raising the visibility of human trafficking, developing responses to the [health needs](#) of trafficked persons, and advocating for necessary services and improved human trafficking policies [2-4, 9-11]. This involvement is reflected in the development of new protocols for identification and treatment of trafficked persons in health care settings, policy statements by organizations of health care professionals, and legislation to require [training](#) of health care professionals in human trafficking and trauma-informed care (i.e., care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma) [16-18]. Recently, the involvement of health care professionals in human trafficking has expanded to encompass the role of mandated reporter.

Mandatory Reporting Laws to Address Human Trafficking

In the US, various laws might require a health care professional to make a report either to law enforcement or child protection agencies as a result of an interaction with a victim or survivor of human trafficking: mandatory child abuse reporting laws, domestic violence reporting laws, and laws requiring reports of knife or gunshot wounds [10]. Each of these laws could benefit trafficked persons, but they also entail potential risks: reporting laws generally entail risks, but requirements to report human trafficking may involve heightened risks due to the vulnerability of trafficked persons related to their mistrust of authorities and fear of their traffickers. Recent developments with respect to US child abuse reporting laws and their incorporation of human trafficking provide a useful illustration of the advantages and the perils of mandatory reporting as a strategy for responding to human trafficking.

Mandatory reporting laws for child abuse. Child abuse reporting laws exist in all 50 US states and the District of Columbia [10, 19]. These child abuse reporting laws require various individuals, including health care professionals, to notify child welfare and/or law

enforcement authorities when they know or [suspect](#) that a child has suffered physical, emotional, or sexual abuse or neglect [1, 10]. The federal Child Abuse Prevention and Treatment Act of 1974 (CAPTA) requires states to have child abuse reporting laws as a condition of receiving federal funds for child abuse and neglect prevention and treatment programs [20]. The 2010 reauthorization of CAPTA includes important definitions. For example, the definition of “sexual abuse” does not explicitly include the term trafficking but encompasses conduct involved in trafficking, such as:

(A) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct ... or (B) the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children [21].

A 2015 amendment to CAPTA further specifies, effective May 2017, that “a child shall be considered a victim of ‘child abuse and neglect’ and of ‘sexual abuse’ if the child is identified ... as being a victim of sex trafficking ... or a victim of severe forms of trafficking in persons” as described in the Trafficking Victims Protection Act [22]. The 2015 CAPTA amendment also gives states the option of treating young adults up to age 24 as victims of “child abuse and neglect” or “sexual abuse” [22]. These recent amendments to CAPTA have significant implications for states’ child abuse reporting laws. Consistent with CAPTA, every state includes sexual abuse or sexual exploitation in its definition of reportable child abuse and neglect, although specific definitions vary [1]. State laws also vary with respect to who is required to report; whether reports are made to child welfare, law enforcement, or both; which types of abuse are reportable; and whether extra-familial abuse (by third parties) is reportable [1]. The significance of these variations would depend on numerous factors specific to conditions in different states. One variation, however, is particularly important: if extra-familial abuse is not currently reportable, a state’s law would likely need to be amended to extend its reach to incorporate reporting of children who have been victimized and trafficked by third parties.

Incorporating trafficking into mandatory child abuse reporting laws. Over the past few years, several states have amended their child abuse reporting laws to include some or all forms of human trafficking. One legal review of the child abuse reporting laws of all 50 states found that, as of December 2015, 14 states covered at least some forms of human trafficking, with 10 including both sex and labor trafficking and 4 addressing only sex trafficking [10]. A medical-legal review of child abuse reporting laws conducted in the same time period found that at least 7 states require reporting of sex and/or labor trafficking of minors [11]. The numerical discrepancy between these two studies may result from the inconsistencies in terminology and definitions mentioned earlier.

Moreover, both studies identified Illinois as a state whose updated child abuse reporting law requires reporting of both sex and labor trafficking to the state child welfare agency, and a recent report analyzing this law's implications for child protection policy and practice found that the state's child welfare agency was encountering significant obstacles in implementing the updated reporting law [12]. Implementation challenges included the need to build capacity to identify, track, and respond to trafficked children; limitations in the scope of the state's child abuse reporting law to cover only abuse by guardians and caretakers; and conflicting agency policies and priorities [12]. All three of these studies identified risks as well as benefits of incorporating human trafficking into state child abuse reporting laws [10-12].

Risks and benefits of mandatory reporting of trafficking. Expansion of child abuse reporting laws to encompass human trafficking could result in significant benefits. Because child abuse reporting laws are mandatory, they should provide an incentive for health care professionals to heighten their awareness of human trafficking and look for signs that their patients may be trafficked or at risk for trafficking. Health care professionals may be the only professionals with whom trafficked children come into contact in a setting that is sufficiently confidential to provide an opportunity for identification. Identification of trafficked children ideally provides both a mandate and an avenue for them to be referred to services that could meet their specific needs. Appropriate investigation by child welfare and law enforcement officials can and should result in protective measures for at-risk or trafficked children as well as prosecution of perpetrators. A growing number of states—up to 20, depending on the criteria used in counting—have enacted “safe harbor” laws designed to treat trafficked children not as criminals and prostitutes but as victims in need of trauma-informed health care and other supportive services [23, 24]; well-designed and implemented mandatory reporting laws might help provide access to these resources.

However, risks to trafficking victims associated with a mandatory reporting system, especially one that fails to achieve its intended purposes, are significant. Although this discussion focuses on the example of child abuse reporting, there are other reporting mandates that might affect trafficked persons, including adults—such as laws requiring reports of domestic or intimate partner violence and those requiring reports of injuries such as knife or gunshot wounds [25]. Mandates for reporting by health care professionals override the confidentiality protections that otherwise apply in health care settings [1]. If trafficking victims and survivors—youth or adults—are aware of a reporting requirement, it could possibly deter them from seeking care or disclosing sensitive information, because they fear reprisal by their traffickers, prosecution by law enforcement (e.g., for prostitution), or deportation by immigration authorities. If reporting resulted in access to real protections and meaningful services, knowledge of that might overcome the reticence of trafficked persons to reveal their situation and have it disclosed. However, in the context of child abuse reporting, states' child welfare

systems have long been overburdened and often lack resources to provide essential care for the children they are charged with protecting [26]. Even when resources are adequate, children and youth in the foster care and juvenile justice systems are at increased risk for being victims of sexual exploitation and human trafficking [1]. Ironically, reporting children to protective services that may not have mechanisms in place to prevent trafficking or to address the needs of those who have been trafficked might not be beneficial. Also, when reports are made to law enforcement rather than, or in addition to, child welfare, the law enforcement agencies may be similarly ill-prepared to connect trafficking victims and survivors to the most appropriate services. These factors have contributed to reluctance on the part of some health care and other professionals to submit mandated reports [27-29].

For the benefits of mandatory reporting to be realized and the risks to be mitigated, several specific measures are essential. Laws must be drafted to include definitions of both sex and labor trafficking that cast the net wide enough to reach trafficked persons, while at the same time including provisions to ensure that the victims and survivors are connected to services that can meet their needs [10, 11]. Mandated reporters and the child welfare and law enforcement officials who receive and investigate the reports must be appropriately trained to identify trafficked persons and to provide, refer, or connect trafficking victims and survivors to specialized services [9-12]. Identified victims and survivors must have access to specialized [trauma-informed care](#) to address their physical and psychological health needs and be aware that those services are available to them [2-4, 13-15]. Perhaps most importantly, child welfare systems must have sufficient resources to protect and support trafficked children brought to their attention and delivered into their care [10, 12].

Conclusion

Health care professionals are moving to the forefront of efforts to prevent human trafficking and to address its harms through identification, trauma-informed care, and advocacy. Mandatory reporting laws—including careful incorporation of sex and labor trafficking into definitions of reportable child abuse—might facilitate the protection of trafficking victims and survivors. To achieve this goal, health care, child welfare, and law enforcement professionals must be trained in trafficking, trafficking victims and survivors must have access to trauma-informed care, and child welfare systems must have the necessary resources to provide meaningful prevention and protection. With measures in place to ensure that the risks of mandatory reporting laws are mitigated, health care professionals can assume the role of mandatory reporters of human trafficking while meeting their ethical obligation to “do no harm.”

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POLICY FORUM

Who Is in Your Waiting Room? Health Care Professionals as Culturally Responsive and Trauma-Informed First Responders to Human Trafficking

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Abstract

Evidence-based practice standards are not yet well defined for assisting potential victims of human trafficking. Nonetheless, health care professionals are learning to be first responders in identifying, treating, and referring potential victims. As more public and private sector resources are used to train health care professionals about human trafficking, more evaluation and research are needed to develop an effective standard of care. Adopting a public health lens and using the “National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care” can guide critical decision making and actions. Through collaboration between researchers and policymakers, lessons learned in health care settings can inform future evidence-based standards of care so that all patients receive the services that they need.

Introduction

Human trafficking, a form of modern-day slavery, is a crime. The initial federal law, the Trafficking Victims Protection Act (TVPA) of 2000, has been reauthorized three times to increase society’s power to address victims’ needs and to put an end to this injustice. Under the law, a trafficking victim is a person induced to perform labor or a commercial sex act through force, fraud, or coercion. Any person under age 18 who performs a commercial sex act is considered a victim of human trafficking, regardless of whether force, fraud, or coercion was present [1].

Health care professionals who encounter a potential victim of human trafficking in a health care setting should be guided by ethical principles, while simultaneously recognizing that other perspectives and standards are needed to guide their actions and decision making. According to Beauchamp and Childress, the fundamental principles governing physician-patient relationships are beneficence (the obligation to prevent harm and promote good), nonmaleficence (the obligation to do no harm), justice (the obligation to provide others with whatever they are owed or deserve), and autonomy (the obligation to respect the self-determination of other persons) [2]. These principles are important directives for health care professionals faced with a potential victim of

human trafficking in a health care setting, and they guide and form the foundation for any effective response. Better service delivery begins with training about human trafficking, adoption of a public health lens, and understanding of social determinants of health. As training programs and the public health lens become more widely adopted, building practice-policy feedback loops will help ensure that evidence-based standards of care are developed and applied effectively to all populations at risk for human trafficking.

Training for Health Care Professionals

To better understand human trafficking, the US Department of Health and Human Services (HHS) in 2008 sponsored a *National Symposium on the Health Needs of Human Trafficking Victims*. This symposium served as a follow-up to its exploratory study on HHS programming for victims [3]. During the symposium, more than 150 health care professionals discussed human trafficking, their role in addressing the needs of victims, and ways to improve the health care system's response to victims. Participants stated that training professionals in the medical field is imperative to improve identification of, and service delivery to, victims [4]. HHS, through its National Human Trafficking Resource Center and with input from both for-profit and not-for-profit organizations, developed and implemented valuable online and in-person training for health care professionals on identifying and responding to trafficking victims [5]. The provision of [training](#) for first responders, e.g., physicians, dentists, nurses, is in alignment with the five-year *Federal Strategic Action Plan on Services for Victims of Human Trafficking in the United States, 2013-2017* [6]. HHS also created the "Stop. Observe. Ask. Respond to Human Trafficking (SOAR) to Health and Wellness Training" to educate health care professionals and other community leaders about human trafficking and victim identification [7].

Early victim identification is an important aspect of training because research has shown that many victims interface with the health care system but few are helped [8]. One study showed that 88 percent of victims had contact with at least one health care professional at some point during the period in which they were being trafficked; however, none were identified or offered assistance to get out of bondage during the encounter [9]. Another study of emergency department personnel found that 29 percent thought human trafficking was a problem in their emergency department population; however, only 13 percent of the study participants felt confident or very confident that they could identify a victim of human trafficking, and fewer than 3 percent had ever been trained to recognize victims [10].

When it comes to identification of human trafficking victims, several barriers exist for both health care professionals and patients. Professional-related barriers include clinicians' lack of knowledge regarding human trafficking, failure to apply [trauma-informed care](#), and cultural assumptions about the victim [11-13]. Patient-related

barriers include patients' failure to self-identify as human trafficking victims due to fear, shame, and lack of awareness of victim status and rights; lack of knowledge of US laws and contractual obligations in cases of labor trafficking; and language barriers and illiteracy. Health care facilities that develop protocols that take into account all these factors will be poised to deliver appropriate health care for victims of human trafficking.

Adoption of the Public Health Lens

According to Jonathan Todres, "Public health methodologies can move us from confronting harm only after millions of people have suffered to strengthening individuals' and communities' capacities to prevent human trafficking" [14]. The public health lens is a powerful tool in the effort to end human trafficking because it focuses on prevention, ending violence, and understanding the social determinants of health [15, 16]. Population health looks at "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" and links these to social determinants on the one hand and policies and interventions on the other [17]. Health care professionals who adopt a public health lens view human trafficking as part of a spectrum of interrelated violence and systemic inequities that are influenced by the social determinants of health.

Understanding the social determinants of health and highly vulnerable populations. Social determinants of health are the circumstances in which people are born, grow up, live, and work that affect health. Families and communities vary in their past experience with and vulnerability to harm. Anyone can become a victim of human trafficking. However, social determinants of health make some groups particularly vulnerable to trafficking. These populations include: people with a history of childhood abuse and neglect; children who have been in foster care or who have spent time within the juvenile justice system; runaway and homeless youth; people with disabilities; undocumented immigrants; people with low incomes; lesbian, gay, bisexual, transgender, and questioning people; migrant workers; and racial and ethnic minorities [18]. With regard to racial and ethnic demographics and human trafficking, very little discourse has occurred and even less research exists. Figure 1 shows that of confirmed sex trafficking victims whose race was known, 40.4 percent were black, 25.6 percent were white, 23.9 percent were Hispanic, 4.3 percent were Asian, and 5.8 percent were other [19]. Likewise, figure 2 shows that of confirmed labor trafficking victims whose race was known, 55.7 percent were Hispanic, 18 percent were other, 14.8 percent were Asian, 9.8 percent were black, and 1.6 percent were white [19]. The high rates of human trafficking within communities of color present an excellent opportunity for professionals, researchers, and policymakers who are knowledgeable about minority health disparities to contribute their expertise to human trafficking prevention and intervention strategies.

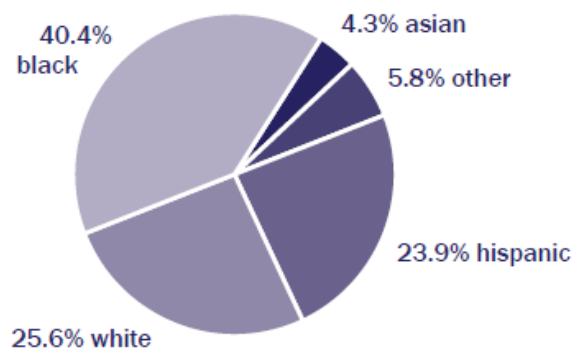


Figure 1. Sex trafficking victims by race. Reprinted from “2013 National Crime Victims’ Rights Week Resource Guide,” © 2013 US Department of Justice Office of Justice Programs Office for Victims of Crime and National Center for Victims of Crime [19].
Note: Data from 2011 US Department of Justice special report [20].

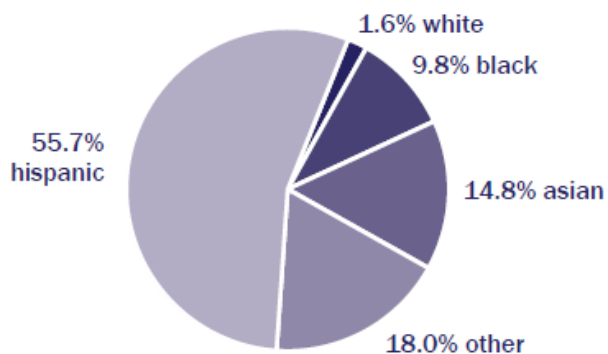


Figure 2. Labor trafficking victims by race. Reprinted from “2013 National Crime Victims’ Rights Week Resource Guide,” © 2013 US Department of Justice Office of Justice Programs Office for Victims of Crime and National Center for Victims of Crime [19].
Note: Data from 2011 US Department of Justice special report [20].

Prevention and intervention strategies. Anti-trafficking and local, state, and national minority health experts can braid together their knowledge about [vulnerable populations](#) and their approaches to best serve these populations. One tool developed by the US Department of Health and Human Services Office of Minority Health is the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The CLAS standards) [21]. The CLAS standards aim to ensure effective, equitable, and respectful care and services that are responsive to diverse needs. They encourage effective communication between the health care professional, health care facility, and the surrounding community. The 15 standards address inequities at every point of patient contact with the health care system and encompass three broad themes: (1) governance, leadership, and workforce; (2) communication and language assistance; and

(3) engagement, continuous improvement, and accountability. Examples of CLAS standards include (1) conducting regular assessments of community health assets and needs and using the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area; and (2) partnering with the community to design, implement, and evaluate policies, practices, and services to ensure their cultural and linguistic appropriateness. By using the CLAS standards, health care professionals and the health care system can better care for victims of trafficking by engaging appropriate community partners and developing culturally competent interventions. In applying cultural competency tools such as the CLAS standards in health care facilities, health care professionals can understand the many stressors faced by these vulnerable populations.

Beneficence and nonmaleficence call for the use of a trauma-informed approach that is sensitive to the patient's past experiences with the health care system and society. A trauma-informed approach to care maximizes healing and recovery while minimizing the risk of retraumatization [11]. Both the CLAS standards and a trauma-informed approach are examples of evidence-based standards; both are directly related to the experiences and risk factors of those who have been trafficked. Health professionals can build upon these standards and use them to address the needs of victims of human trafficking. Evidence-based practice standards such as the CLAS standards and a trauma-informed approach that can be applied effectively to all populations will be shaped by practice-policy feedback loops.

Building Practice-Policy Feedback Loops

Relative to other problems such as intimate partner violence, anti-trafficking practice-policy feedback loops, in which health care professionals and researchers inform the work of policymakers, are in their infancy. While some researchers have developed and tested appropriate screening tools, little research exists on the evaluation and development of evidence-based practices for identifying and treating victims of trafficking [22, 23]. Progress has been made, however, in developing and disseminating recommended practices and protocols in institutions [24]. Health care professionals can also seek guidance from trauma-informed care resources such as the Substance Abuse and Mental Health Services Administration's National Center for Trauma-Informed Care and through learning networks [11]. A large and well-organized learning group is the Health, Education, Advocacy, Linkage (HEAL) Network, which provides a platform for interdisciplinary health professionals to discuss recommended care for treating victims of human trafficking. Members can join working committees focused on topics such as education and training, prevention, and protocol development [25]. The goal is that health care professionals trained in identifying trafficking victims will build up an [evidence base](#) of care needs and treatment outcomes that will inform standards of care, which can be further refined as they are used in practice. The accumulation of

knowledge through practice-policy feedback loops will move the anti-trafficking field forward over time.

Conclusion

The US health care system relies on the belief that health care professionals follow codes of ethics and a body of knowledge grounded in evidence-based research and training. Although quantitative evidence-based research accumulates over time, health care professionals can contribute to the body of knowledge of trauma-informed and culturally competent care by sharing and testing potential promising practices. As in other fields, these changes will not wait for comprehensive evidence-based research. The process of learning is much more fluid. Lessons learned in health care settings can inform future evidence-based standards of care so that all patients receive the services that they need. With training, a public health focus, and practice-policy feedback loops, health care professionals will be able to see, understand, and respond appropriately to victims of human trafficking in their waiting rooms.

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MEDICINE AND SOCIETY

Human Trafficking in Areas of Conflict: Health Care Professionals' Duty to Act

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Abstract

Given the significant global burden of human trafficking, the ability of clinicians to identify and provide treatment for trafficked persons is critical. Particularly in conflict settings, health care facilities often serve as the first and sometimes only point of contact for trafficked persons. As such, medical practitioners have a unique opportunity and an ethical imperative to intervene, even in nonclinical roles. With proper training, medical practitioners can assist trafficked persons by documenting human trafficking cases, thereby placing pressure on key stakeholders to enforce legal protections, and by providing adequate services to those trafficked.

Introduction

The United Nations (UN) Office on Drugs and Crime defines trafficking as

the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs [1].

Across the globe, approximately 21 million people are victimized by human trafficking [2]. All types of trafficking affect all genders. Women and girls are more often identified as trafficked in the sex industry and as domestic servants; males are less often identified as victims of trafficking and, when they are, it is often for other forms of labor, like agricultural, factory, and construction work [3]. Vulnerability to exploitation increases substantially in times of conflict. During war, the erosion of the rule of law, corruption of legal and political authorities, and evolution of criminal networks can all contribute to an environment ripe for trafficking [4, 5]. Even the presence of humanitarian aid workers,

who have more liquid assets than local beneficiaries, can increase demand for sexual services or goods made through exploitative labor, leading to an increase in or the development of trafficking.

In 2000, the UN's Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children [1] provided an international definition of the crime of human trafficking (more comprehensive than its 1921 predecessor, which was drafted under the auspices of the League of Nations [6]) and established guidelines for UN states for the prevention and combatting of human trafficking [1, 7]. In 2004, the UN Commission on Human Rights appointed a special rapporteur to focus on the human rights aspects of trafficking in persons [8]. These developments have led to discussion within the UN Security Council about whether trafficking during conflict may constitute a war crime [7], but, at the time of this writing, the UN has yet to make this determination. Despite these developments and discussions, the number of prosecutions remains relatively low [5]. This is the result of multiple factors, but a major contributor is the lack of documentation or evidence. Trafficking in persons is often not identified and properly investigated in the field in real time, particularly in crisis situations when clinical and forensic resources are scarce and the context poses great challenges [5]. But without apt [documentation of trafficking](#), which enumerates and describes those affected, resources will remain in short supply.

In this paper, we will explore the role of clinicians outside of their purely clinical duties. Specifically, this paper discusses the ethical imperative of clinicians—when relevant—to forensically document evidence of trafficking among populations served during conflict. We argue that acting outside of a solely clinical function, in or outside of conflict settings, is not a novel concept for clinicians and, further, that practitioners' nonclinical actions also benefit patients.

Trafficking During Conflict

The primary role of health care practitioners during conflict is to provide medical and mental health services to populations in need, both civilians and noncombatants. Health care facilities have been recognized as safe havens, providing care to people suffering from routine afflictions such as exacerbations of chronic disease [9] as well as injuries and illnesses specifically related to the conflict. As a conflict wages on, large groups of people can be displaced, fleeing for safety. During this phase, communities often experience decreased access to safe water, medications, food, and proper shelter, which can increase rates of infectious disease and malnutrition, making people more vulnerable to exploitation [9]. Some noncombatants move in with kin in other areas or even stay in their homes. Regardless of setting—and even outside of the directly involved conflict areas—noncombatants are frequently unable to safely earn a living in the positions they held before the conflict. In addition to the factors previously listed, the desperation of noncombatants to support their families can make them vulnerable to being trafficked

[10], and the crisis itself dampens the state's ability to intervene and respond to the crime of trafficking of persons [4].

In fact, there is ample evidence of human trafficking during conflict: most recently, International Organization of Migration (IOM) data from 2014 and 2015 confirms that, as part of the Iraqi conflict, Yazidi women and children were abducted by the Islamic State for domestic and sexual exploitation; migrant workers have been held by militia groups for forced labor; armed opposition groups have forcibly recruited children to fight in the Iraqi conflict; and human organs have been collected and sold [5]. In the Syrian conflict, some families have sold young daughters into marriage to "protect" them from sexual assault and provide financial support. Another "protective" measure called "temporary marriage" or *mutah*, which unites a man and woman as husband and wife for an agreed upon period of time [11] and largely affects internally displaced persons and refugees, has increased [5]. Additionally, in a common form of labor trafficking, Syrian refugee children have been seen begging and selling small items on the street [5]. Furthermore, as frequently occurs in conflict, many children are unaccompanied or separated from their usual caregivers. It is common practice for unrelated adults to take them in [12], but not all of these adults are well intentioned and some of these children end up trafficked in a multitude of ways [13].

The Ethical Imperative of Clinicians in Conflict Areas

Because trafficking does not require harboring of persons, trafficked persons may present for health care for a variety of reasons, including primary care and interventions during acute illness or injury caused by their trafficking situation [14, 15]. There is evidence that clinicians, when appropriately trained, can effectively identify patients with a trafficking experience [16, 17], and several guidelines exist to help clinicians develop appropriate techniques for interviewing and examining patients who may be trafficked [18–20]. But screening in conflict settings involves special difficulties that may not pertain to stable environments, such as an increased physical danger to both the patient and practitioner given the general context of conflict and the lack of accountability of and protection by state and international legal systems [21]. Still, even without governmental support, clinicians have the opportunity to practice a form of transitional justice—aimed at redressing the legacies of massive human rights abuses [22]—by providing medical and psychological care to trafficked persons and properly documenting evidence of human trafficking [23].

Health care practitioners have served in nontherapeutic capacities in conflict zones for decades, although not always in ways consistent with their noble calling. Physicians have participated in torture interrogations [24] and performed medical experiments without consent on captives taken during conflict [25, 26]. But practitioners have also specifically documented physical and mental injuries of noncombatants, and these medical records and documents, considered impartial and trustworthy because of their authorship, have

been used as [evidence](#) of war crimes committed [27]. Physicians for Human Rights trains and supports local clinicians on appropriate methods of forensic documentation for just this purpose [27]. Forensic documentation involves gathering information about the medical history, collecting and documenting evidence from the patient's body, and recording pertinent physical exam findings for the purpose of criminal investigation and documentation. This information may be used in court, if needed, and the health care worker may be asked to testify as well [28]. Because it is not directly crucial to the provision of medical or mental health care, it is not considered a clinical activity, but forensic documentation is within the scope of practice of trained clinicians in conflict settings.

Although some may argue that clinicians should only provide clinical care, receipt of a [forensic exam](#) may contribute to improved mental health because trafficked patients have told their story to someone with the power to be heard. In fact, some nurses, physician assistants, and physicians already serve in a strictly forensic capacity, performing sexual assault forensic examinations (SAFE) for survivors of sexual assault. Acting in this capacity, the SAFE examiner only performs the exam for the purpose of evidence collection, in a setting where the survivor can also receive medical and psychological care. However, the exam itself can be empowering to someone recently victimized: by choosing the exam, the survivor exerts autonomy—with the right to refuse any part of the history taking or physical exam—and is believed.

Conclusion

The significant global burden of human trafficking will require multiple actors in varying sectors, including the health, legal, and political arenas to adequately combat its devastating effects. Clinicians are in the unique position of serving as the first and sometimes only point of contact for trafficked persons and, as such, have an ethical duty to act on their behalf. Providing services for and documenting those who are trafficked in conflict zones is challenging, but, with proper training and purposeful efforts, health practitioners can have an important, positive impact in the lives of trafficked persons and survivors.

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MEDICINE AND SOCIETY

Caring for the Trafficked Patient: Ethical Challenges and Recommendations for Health Care Professionals

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Abstract

Human trafficking is an egregious human rights violation with profound negative physical and psychological consequences, including communicable diseases, substance use disorders, and mental illnesses. The health needs of this population are multiple, complex, and influenced by past and present experiences of abuse, neglect, and exploitation. Effective health care services for trafficked patients require clinicians to consider individual patients' needs, wishes, goals, priorities, risks, and vulnerabilities as well as public health implications and even resource allocation. Applying the bioethical principles of respect for autonomy, nonmaleficence, beneficence, and justice, this article considers the ethics of care model as a trauma-informed framework for providing health care to human trafficking victims and survivors.

Introduction

Health care is an important component of broader anti-trafficking efforts, since profound physical and psychological illnesses and injuries can be results of human trafficking. While in captivity, trafficked persons might seek or be brought for health care for myriad injuries, infections, and chronic conditions, including burns, penetrating wounds, fractured bones, traumatic brain injuries, chemical exposures, heat exhaustion, dehydration, malnutrition, communicable diseases, substance use complications including overdoses, sexually transmitted infections (STIs), unsafe abortion complications, chronic pain syndromes, and chronic untreated conditions and their sequelae [1-4]. Acute episodes of intense anxiety, depression, traumatic stress, dissociation, self-injury, and suicidality as a result of the psychological trauma can also prompt victims or survivors to present in health care settings [1-4]. Research suggests that up to 87.8 percent of trafficked persons access health care [3, 5-7]. Health care visits represent unique opportunities for health care professionals to provide clinical care and offer assistance to victims and survivors of trafficking.

Due to the complexity of the trauma experienced, trafficked persons can have difficulty establishing rapport and trust with figures of authority like clinicians, and this difficulty is likely to persist beyond the period of captivity [8, 9]. Indeed, interacting with health care

professionals can be anxiety provoking for trafficked persons whose exploitation is frequently intertwined with histories of abuse, neglect, rejection, and betrayal by family, friends, and intimate partners; and people in child welfare, education, and other positions of trust [9, 10]. Additionally, because of the threat of retaliation by a trafficker against a trafficked person and his or her loved ones, the mere possibility of being identified as trafficked could be a source of fear and internal conflict even if the trafficked person wants to be recognized as a victim and assisted [5, 8, 11].

This article uses Beauchamp and Childress's principles of respect for autonomy, nonmaleficence, beneficence, and justice [12] to examine some of the ethical dilemmas faced by health professionals when identifying and providing care to trafficked persons. Topics covered include the right to privacy and professional interpreters, the importance of avoiding unnecessary questions and reports to third parties without the patient's consent, and the barriers to accessing and providing appropriate care. Finally, the ethics of care model is proposed as a trauma-informed framework for providing better care to human trafficking victims and survivors.

Respect for Autonomy: Should Clinicians See Trafficked Persons as Helpless Victims or Agents with Decision-Making Power?

The movement to limit the use of the term "trafficking victim" in the anti-trafficking lexicon in favor of such terms as "trafficked person" or "trafficking survivor" is an attempt to counteract the misconception that persons who are or have been subjected to this form of interpersonal abuse are helpless victims [13]. Although it is important to recognize when and how trafficking victims do need help, particularly from clinicians, misconceptions that promote a view of a person as globally helpless are harmful because they can undermine our conceptions of trafficking victims as moral agents who can retain or regain capacities for self-determination and decision making. While the need to facilitate trafficking survivors' growth in their sense of self and agency might have given rise to this linguistic movement, the premise behind it—that trafficked persons lose agency and autonomy, in all respects—is static and flawed. It is a misconception that neither accounts for victims' tenacity in resisting and defying their traffickers while in bondage, nor their capacity for healing and dynamic growth over time once removed from the exploitation. Although influenced by circumstances and feelings of anger, fear, or shame, acts of obedience as well as defiance arguably should be seen as decisions and conscious expressions of autonomy and self-preservation in the context of limited choice and control at a given point in time. As an example, a trafficked person who fears never being rescued may make the calculated decision to obey the trafficker, perhaps to a fault, in order to gain the trust and privileges needed to undertake a successful escape attempt. In the context of health care, trafficked persons who present to health care facilities for clinical treatment are actively gauging their surroundings and the trustworthiness of health care personnel with whom they interact and making decisions about whether to hide or disclose their circumstances and whether

to accept or decline assistance [14]. As agents with decision-making power, which they exert to varying degrees depending on the situation, trafficked persons possess autonomy, and the dynamic nature in which they operationalize it in clinical contexts should be acknowledged by clinicians.

Like any patient, trafficked persons are deserving of dignified, respectful health care. Failure to ensure privacy, to enlist professional medical interpreters when needed, and to explain the legal limitations of [confidentiality](#) (i.e., mandatory reporting requirements) can undermine the autonomy of patients. In the case of trafficked patients, each of these components is necessary for encouraging independent and informed decisions about whether to disclose and what to disclose about their experiences, for example. Clinicians' failure to engage trafficked persons in an independent and informed decision-making process is an important way in which the principle of respect for autonomy might be breached in the course of caring for trafficked persons.

"Right Versus Right" Actions: Do All Right Actions Result in Good Outcomes?

Health care professionals have an obligation to first do no harm (nonmaleficence), either through acts of omission or commission, and to act in the best interests of their patients (beneficence). Accordingly, positive actions include the *removal from harm*, *prevention of harm*, and *promotion of good*. To carry out these duties, clinicians must seek to understand their patients' needs, wishes, goals, priorities, risks, and vulnerabilities, and factor these into the plan of care.

While removing from harm presumes recognizing that a patient is being trafficked, the principle of nonmaleficence cautions against generating patients' admission or disclosure that they are being trafficked as a primary goal of the patient-clinician interaction. For a number of reasons, trafficked persons are highly unlikely to disclose their situation when accessing health care [5, 8, 9, 11, 14-16]. Aggressive attempts to confirm a suspicion about trafficking and obtain an admission or disclosure can be psychologically harmful for the trafficked person, potentially triggering intense stress, anxiety, and fear [14, 17]. This would seem to be especially true when disclosures are unwittingly pursued by a clinician in the presence of the trafficker. Similarly, probing for the details of an admitted or disclosed trafficking situation can be retraumatizing, possibly provoking physical and psychological distress as past trauma is re-experienced in the present and thus should be restricted to obtaining the minimum amount of information needed for guiding clinical decisions [17]. For example, following an adolescent girl's disclosure of being sex trafficked, a clinician's curiosity about the total number of men she has been forced to service will not change the decision to file a legal report of child maltreatment and provide prophylactic treatment for STIs but could distress the patient if asked.

Following an admission or disclosure from a trafficked patient, how should clinicians best promote good for the patient? [Mandatory reporting laws](#) are intended to enhance patient and community safety and accountability [18]. If the trafficked patient is a child, it is required by law in all 50 states to report child abuse [18]. If the trafficked patient is an adult, health professionals are required by law in all but three states to report injuries caused by weapons or injuries caused in violation of criminal law, suspected abuse, or domestic violence [19].

When mandatory reporting laws do not apply to a particular case, health care professionals—who, in general, lack the means for protecting trafficked patients outside of clinical settings—must consider the ramifications of reporting to third parties without their patients' consent and despite their patients' declining assistance. Without the law in their favor, the ability to safely and expeditiously remove a victim of trafficking from harm may be limited. Thus, this type of medical paternalism could place trafficked patients and their loved ones in danger of retaliation by the trafficker and perhaps suggest to some that health professionals are untrustworthy and uncaring. Patients' decisions about whether to hide or disclose their situation, and whether to accept or decline clinical assistance, are based on those patients' firsthand experience and knowledge of the potential repercussions. For this reason, their decisions must be respected to the extent possible when mandatory reporting laws and the resources therein provided do not apply.

Is Justice Expressed in the Health Care Trafficked Persons Receive?

In general, trafficked persons have less access to health care services than other people due to the hidden and controlling nature of the crime. Moreover, persons in abusive, exploitative situations prioritize activities focused on day-to-day survival over maintenance activities for overall well-being. These priorities explain trafficking victims and survivors' greater use of complaint-based episodic acute care services (e.g., minute clinics, urgent care centers, and emergency departments) rather than long-term comprehensive primary care services. For example, one study found that in a cohort of sex trafficking survivors, 63 percent reported having received care in an emergency department, and only 22 percent reported having received care in a primary care office [3]. Overall, primary care appointments are scarce and the waiting times long [20]. However, even if trafficked persons have access to primary care, unforeseen events can impede their ability to follow through on recommendations or follow-up with scheduled appointments, and they might, in the end, be "fired" by some clinicians due to repeated no-shows. Keeping in mind the long-term health benefits of comprehensive primary care and the cost savings associated with its focus on preventative and maintenance health care [20], the unique circumstances surrounding the care of trafficked persons appears to challenge distributive justice (the fair distribution of resources) by limiting trafficked persons' ability to access appropriate and affordable health care outside of acute injuries and illnesses.

Many health care professionals have not received the [education](#) and training necessary to recognize the signs and symptoms of exploitation/trafficking in patients with any consistency [16, 21]. Consequently, health care professionals are at a disadvantage because they can be ill prepared to comprehensively assess and respond to the full and complex spectrum of trafficked persons' health needs. Particularly in acute care settings, a comprehensive assessment of the patient's needs, wishes, short- and long-term goals, risks, and vulnerabilities is difficult to carry out or immediately incorporate into a treatment plan. Thus, the ongoing assessment of resource needs and fair allocation among the most vulnerable is also challenged in our care of trafficking victims and survivors.

As with all patients, health care professionals are faced with treatment decisions for trafficked persons that incorporate considerations such as possible medication nonadherence and limited ability to follow through with long-term treatment plans. Clinicians must assess the benefits of each possible treatment plan, weigh the potential risks, present these to the patient, and try to provide consistent, appropriate care to all. In addition, clinicians must consider the risks to the individual and community as trafficked persons can present with needs related to communicable diseases, [substance use](#) disorders, and mental illnesses. In the case of STIs, for example, if the clinician suspects that the patient is being trafficked, a point of care single-dose treatment modality, if available and effective, would generally be preferable to a recurring-dose, multiple-day treatment plan that carries a higher risk of nonadherence. Similarly, while pre-exposure prophylaxis (PrEP) can reduce the risk of HIV seroconversion, PrEP requires daily medication adherence and regular follow-up visits for refills to prevent infection and antiviral resistance [22]. Failure to test or initiate therapies due to assumptions about medical treatment adherence must be carefully weighed, and alternatives for more appropriate care that accounts for the unique challenges and circumstances of the patient should be sought as needed and as available. Among trafficked persons, who possess little or no control over access to barrier protection or personal protective equipment, treatment for the same infections and injuries might need to be frequent, and clinicians must remain compassionate and nonjudgmental.

A Trauma-Informed Ethics of Care

Patient care, by definition, is an interpersonal exchange—a human relationship forged by necessity and hardly devoid of sentiment. The philosopher Joan Tronto's ethics of care outlines four phases of care (caring about, caring for, care giving, and care receiving) and their corresponding ethical dimensions (attentiveness, responsibility, competence, and responsiveness) that infuse actions taken and decisions made in the course of care with relational and contextual moral value [23]. The emphasis placed on the caregiver and care-receiver relationship in this care ethics theory is worth exploring in the context of

caring for the trafficked patient, especially as it relates to the trauma-informed approach to care.

The trauma-informed approach to care is frequently invoked and widely touted as a useful framework for caring for victims and survivors of physical and psychological trauma [24]. Especially as it relates to the care of victims and survivors of human trafficking, effective care requires a sensitive, compassionate, measured approach with attention to health care practices—such as disrobing patients without warning or proper verbal consent—that could trigger fear, stress, shame, and feelings of inadequacy and stigmatization for that patient. According to the US Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration, the trauma-informed approach:

- 1. *Realizes* the widespread impact of trauma ...
- 2. *Recognizes* the signs and symptoms of trauma ...
- 3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
- 4. Seeks to actively resist *re-traumatization* [24].

A close look at the four elements of the trauma-informed approach reveals parallels with Tronto’s four phases of care and dimensions of care ethics (see table 1). Thus, Tronto’s ethics of care can serve as a trauma-informed framework of care guided by the four bioethical principles.

Table 1. Parallels between the ethics of care and the trauma-informed approach to care [23, 24]

Ethics of care	Trauma-informed approach	Parallel concepts
"Caring about" refers to clinicians acknowledging and being concerned about the need for care and condition of patients with attentiveness to their needs, wishes, goals, priorities, risks, and vulnerabilities.	Understands the widespread impact of trauma.	Being attentive to others’ needs, goals, risks, and vulnerabilities requires understanding the impact of their trauma.

"Caring for" involves accepting and assuming the responsibility of improving the condition of patients to the extent possible in the context of scarce appropriate resources.	Recognizes the signs and symptoms of trauma.	Assuming responsibility for improving the condition of others requires recognition of the signs and symptoms of their conditions.
"Care giving" is the actual delivery of care with competence such that it is appropriate and effective quality care.	Responds by fully integrating knowledge about trauma into policies, procedures, and practices.	Delivering appropriate and effective care competently requires comprehensively responding to needs, goals, risks, and vulnerabilities in all aspects of care.
"Care receiving" calls for clinicians to consider the patients' responsiveness to the care they are receiving so as to address any perceived shortcomings of care.	Seeks to actively resist retraumatization.	Ensuring that care is responsive to needs, goals, risks, and vulnerabilities requires actively seeking to avoid potential shortcomings of care such as retraumatization.

Conclusion

Both principlist and care ethics approaches to trauma-informed care require a clinician's attention to respond to the needs, wishes, goals, priorities, risks, and vulnerabilities of the patient and incorporate them into the care plan. Additionally, both demand that the patient's perspective about the care—whether it's perceived and experienced as fair, appropriate, or retraumatizing—be considered and corrective action be taken. Clinicians who interact with trafficked persons will be more effective health care professionals if they are respectful of their patients' wishes, sensitive to the complexity of their needs, and cognizant of factors that might have rendered them vulnerable to being trafficked in

the first place—such as child abuse and neglect—so as to more empathically care for them while proactively avoiding their retraumatization. Indeed, it is reasonable to conclude that integrating these elements into the care of trafficked persons and trafficking survivors will yield better, and perhaps more ethical, results.

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MEDICINE AND SOCIETY

Groupthink: How Should Clinicians Respond to Human Trafficking?

William Polk Cheshire, Jr., MD, MA

Abstract

Human trafficking is a pervasive problem that exceeds the capacity of social and organizational resources to restrain and for which guidelines are inadequate to assist medical professionals in responding to the special needs of victims when they present as patients. One obstacle to appropriate disagreement with an inadequate status quo is the lure of group cohesion. "Groupthink" is a social psychological phenomenon in which presumed group consensus prevails despite potentially adverse consequences. In the context of the medical response to human trafficking, groupthink may foster complacency, rationalize acquiescence with inaction on the basis of perceived futility, create an illusion of unanimity, and accommodate negative stereotyping. Despite these inhibiting influences, even in apparently futile situations, medical professionals have unique opportunities to be a force for good.

Introduction

An estimated 18,000 people are trafficked into the United States each year and forced into commercial sex work or hard labor [1]. These persons are subject to physical, sexual, and emotional violence and suffer from neglected health conditions [2]. Their abuse often remains hidden from mainstream society. Rarely do they self-identify in health care settings, whether out of fear, intimidation, shame, language barriers, or limited interaction with medical personnel [1]. A majority of them encounter a health care professional and receive episodic medical care while under traffickers' control and yet frequently go unrecognized as victims of human trafficking [3]. In some cases, clinicians may not consider the possibility that the patient is a victim and thus may unknowingly miss relevant clinical clues.

Studies of human trafficking victims in health care settings have identified the need for health care professionals' increased [education](#) about and awareness of the phenomenon of human trafficking and how to identify and treat its victims [1, 2]. This need is real, yet factual knowledge alone is insufficient to address the problem. Health care professionals must also reflect on the ethical aspects of responding to human trafficking. Education should include more than information, because mere facts do not compel action. A robust moral response also requires the prompting of conscience, the stirring of

empathy, willingness to act, prudential judgment, and confrontation of complacency where it exists.

Complacency is easily overlooked. One may probe for it by inquiring whether, in response to a problem as widespread as human trafficking, society is appropriately outraged and committed to taking all actions necessary to address the problem. A greater cultural response is needed, but, until then, the medical profession should be among the forces that are stepping out and leading the response. One of the barriers to such initiative can be psychological cohesiveness around an inadequate status quo.

The Dangers of Groupthink

Among the factors that may limit the medical response to human trafficking is the psychological phenomenon of conformity to group norms. There are many types of groups, which in general may be defined as collections of people who interact with one another; share interests, goals, and norms; and are unified in identity and purpose [4]. From the perspective of sociology, the medical community is a group comprising people who may work together as teams or may not interact directly but who share a common identity, base of knowledge, set of ethical principles, and commitment to medical service. Medical professionals constitute a specific type of a medical community that encompasses mastery of a complex body of knowledge and skills as well as a social contract with society that includes adherence to a code of ethics; self-regulation; and a commitment to competence, integrity, altruism, and service in the public good [5, 6]. A group's success depends in part on each member's loyalty to the group's mission.

Although group unity is essential for effectiveness, it can become excessive. Too much cohesiveness within a group's attitudes or behaviors can be a symptom of "groupthink," a term coined in 1971 by Irving Janis [7] to describe the "nondeliberate suppression of critical thoughts as a result of internalization of the group's norms" [8]. When groupthink occurs, social conformity shapes the group's dynamics such that members of the group continue the policies and actions to which the group has committed itself, even when the results have negative outcomes or a group member's conscience is troubled. The inclination to seek concurrence with other group members overrides reappraisal and consideration of alternative courses of action [7].

Janis identified eight symptoms of groupthink—invulnerability, rationale, morality, stereotyping, pressure, self-censorship, unanimity, and mindguards [7, 9]—some of which may apply in particular (but not all) instances of the medical evaluation of potential victims of human trafficking. For the purpose of this discussion of the symptoms of groupthink and their ethical implications, the in-group refers to members of the medical community who are not well-educated in human trafficking.

Invulnerability. Most or all members of the in-group share an illusion of invulnerability that leads to an attitude of overconfidence. Groupthinkers tend to feel falsely optimistic in the face of danger and willing to take excessive risks or ignore warnings [7]. This is not to suggest that the health care professional encountering a patient who is a victim of human trafficking is likely to subject the patient to excessive medical risks. Rather, even well-intentioned clinicians who are concerned about victims of human trafficking should ask themselves whether they might be subject to an unconscious bias from social insulation from the patient's plight that might lead them to underestimate the dangers that a potentially trafficked patient faces or ignore clinical clues that ought to warn of ongoing risks to the patient. Although not direct evidence of health care professionals' social insulation, disparities between their awareness of the prevalence of human trafficking and their belief that it impacts their own medical practice suggest a possible cognitive sequestration. For example, a survey of 180 emergency medicine staff in the US found that though 79.4 percent knew what human trafficking was, only 26.7 percent thought it affected their patient population, while 59.4 percent were uncertain [10]. Health care professionals who feel safe and secure in their own communities should make an effort to be intentional in empathizing with their patients' vulnerabilities in order to avoid underappreciating that human trafficking ultimately endangers all communities, including their own—for example, through the spread of sexually transmitted infections and the tolerance of human abuse.

Rationale. Groupthinkers not only ignore warning signs but also construct rationalizations to discount negative feedback that, if accepted, might cause them to reconsider their assumptions [7]. An especially potent rationalization is in the futility of action. In the first ethics case in this issue, Kathy, a medical student practicing in Kathmandu, is told that there is nothing she can do to stop the abuse of her patient. Kathy has no recourse in her desire to remove her patient from an [abusive environment](#) or to change the social hierarchy in Nepal—conditions causing her patient's medical problems. If Kathy or her team were to fall into groupthink, they might acquiesce in the rationalization that offering further medical care would be futile because their patients would inevitably return with reinfections and repeated injuries. However, the medical care they provide at that moment is itself not futile, in that it achieves its intended immediate physiological goal to improve health and extend life. And deeds of compassion are never futile. Over time, the dedication of Kathy's medical team to caring for all kinds of people, including victims of human trafficking, might even inspire and spur the conscience of the local community and, in unforeseen ways, contribute to initiatives that could reorder that society from within.

Morality. Groupthink reinforces belief in the inherent morality of the in-group and makes it easier to overlook the ethical consequences of decisions while inconvenient ethical concerns are left unspoken or are even suppressed [7]. This attitude, which affects all of us at one time or another, is illustrated in the second case in this issue, in which Dr. W

considers disregarding ethical and legal requirements for [medical record documentation](#) out of a belief in the inherent morality of providing gynecological care to a vulnerable and underserved patient population.

In the health care professions in general, a bias toward the inherent morality of existing, praiseworthy, already time-consuming medical projects could potentially relegate efforts to educate ourselves or others about human trafficking to a lower priority. Time and resources are limited, and there may be a bias to continuing what one is already doing. Such a bias in many cases may be appropriate. The point to derive from the groupthink phenomenon is that priorities should periodically be reassessed.

Stereotypes. Groupthink mentality stereotypes anyone who disagrees with the group [7]. The problem for human trafficking, by contrast, is not that medical practitioners necessarily disagree with others who approach the issue differently, but that they may at times unconsciously stereotype trafficking victims as less important than other patients. Such stereotyping can be a form of groupthink insofar as attitudes toward people from similar backgrounds can be shaped by television portrayals or political rhetoric suggesting, for example, that undocumented aliens are a threat to society. Such unconscious social biases are a potential threat to the provision of compassionate care and should be resisted.

A professional approach to caring for trafficked persons bears in mind that they are victims, and as such their injuries or sexually transmitted infections are not the result of self-neglect or moral failure. Human trafficking victims are marginalized and may be subject to repeated physical assault or sexual violence and, therefore, merit our care and concern. In most US states, adolescents can be prosecuted for prostitution [11]; young people who are trafficked for sexual exploitation—which may be unknown to clinicians—may be viewed as criminals, although in fact they are victims coerced into servitude [11, 12]. The very conditions of confinement and abusive treatment can produce psychological symptoms and behaviors that can be mistaken for personality disorders [13], which are stigmatic [14].

Pressure and self-censorship. Groupthink mentality may apply pressure to conform to any member who expresses doubt or challenges the group's direction [7]. This aspect may not apply so much to medicine, where the in-group is dispersed, although self-censorship may quell dissent.

Those who are caught up in groupthink may self-censor by avoiding deviation from the perceived group consensus [7]. One form of medical consensus might be a detail in the patient's case history that, although unexplored or even known to be erroneous, has been repeatedly documented in the medical record. During a medical encounter it may be easier—and, for the moment, safer for the patient—to go along with incorrect

information already established in a medical record. For example, a clinician might avoid investigating further and documenting whether the man claiming to be the patient's uncle is actually her pimp or that the patient who registered as age 19 is actually 16. Rectifying the omitted or incorrect information could endanger the patient by exposing him or her to retaliatory abuse. Clear guidelines for clinicians are needed because, if the clinician is aware that the patient is being trafficked, in some states the law may require the clinician to notify authorities [15]. A compelling case can be made for judiciously engaging, within legal boundaries, in this aspect of intentional self-censorship (not groupthink), which places the safety of the patient before other considerations. By self-censoring, an immediate crisis is averted, although dealing with other issues is postponed.

Unanimity. Because dissent is discouraged, groupthink creates an illusion of unanimity within the in-group. Statements that accord with the majority view are encouraged and freely expressed, whereas silence from those who think differently may be misinterpreted as assent. Each member may then conclude that the majority opinion is true and the current course of action correct [7]. The group might come to the premature conclusion that, because dissenting views are not being expressed, all that might reasonably be done is already being done and further efforts would be futile.

In resisting the groupthink that gravitates toward complacency in accepting the status quo, health care professionals should take the initiative to speak out more about the problem of human trafficking and partner with organizations and agencies that are developing helpful interventions.

Mindguards. Those entangled in groupthink will sometimes protect other members of the in-group from adverse information that would challenge the direction of the group, bring into question the morality of its past decisions, or undermine confidence in its leadership [7]. Combining and expanding upon the first and second ethics cases in this issue, suppose Kathy, a medical student, rotated next with Dr. W. Kathy might be reluctant to follow the law and accurately document the girls' medical details, because doing so could expose Dr. W's ethical compromise—if she did decide to treat the girls—which could have adverse consequences for her mentor Dr. W and for the continued provision of health care to the population of sexually trafficked women in the area. In a case of divided obligations such as this, loyalty to the group influences ethical decisions.

Conclusion

The framework of groupthink helps to explain how even well-intentioned medical professionals can, by going along with consensus, become participants in unnecessarily ineffective responses to serious health needs. Participation in groups, whether by actions, by attitudes, or by adopting uncritical habits of thought such as groupthink, entails personal moral responsibility. Analysis of the contours of ethical complicity must

consider acts of commission and omission as well as timing, proximity, certitude, knowledge, and intent [16–18].

Medical history is replete with unsettling reminders that it is possible for clinicians insufficiently to resist the ineffective or, in some instances, ethically questionable directions of a group. Medical history is also a story of health care professionals who have stood apart from their group, resisted an inadequate or complacent consensus, and led society in the direction of moral progress. The most appropriate ethical path is not always easily discerned. When moral matters are unclear, a valid guiding principle is to focus our care and compassion foremost on all our patients.

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IMAGES OF HEALING AND LEARNING

Art Therapy Exhibitions: Exploitation or Advocacy?

Terri Davis

Abstract

Promoting awareness of human trafficking by sharing trauma survivors' art and summaries of their life stories suggests ethical complexities that have been typically neglected by bioethicists. Although these survivors voluntarily share the objects they created during art therapy sessions, they are still at risk of harm, including further exploitation, due to their vulnerability, high rates of victim sensitivity, and the mental health consequences of their traumatic experiences. While some argue that the benefits of sublimation and art therapy for human trafficking survivors make sharing their art worth the risk, anti-trafficking organizations and supporters of such art exhibitions have responsibilities to be trauma informed.

Because you have listened to my story I can let go of my demons.

Murasaki Shikibu [1]

Introduction

Psychologists and others working with trafficked persons use art therapy to facilitate nonverbal expression of the trauma experience, which may decrease avoidance of emotion [2]. Art was first considered therapeutic after psychologists observed drawings created by the mentally ill. The use and recognition of art along with typical psychotherapeutic interventions increased in the 1930s [3]. It wasn't until the 1990s, however, that art therapy became applied specifically to posttraumatic stress disorder (PTSD), including the treatment of survivors of human trafficking [3]. Art therapy, used as an alternative or supplemental therapy, shows promise in amelioration of posttraumatic stress and traumatic memories through stimulating the patient's senses, thereby facilitating revelation and self-discovery [3]. Lidia Gorceag, a psychologist in Moldova who uses art therapy in treating trafficking survivors, describes art therapy as "a very good exercise. A life road. The woman reproduces the most important events she has been through in the images. She usually draws some symbols, and these images serve as benchmarks for further therapy sessions" [4].

Artwork created by human trafficking survivors during art therapy treatment for PTSD is being used by a small number of advocacy groups to promote awareness of human

trafficking. Artists donate their works and receive no financial remuneration. For example, the Awakenings Foundation Center, an organization dedicated to showcasing the artistic works of survivors of sexual violence, sponsored an exhibition in Chicago titled “The Art of Healing” during National Slavery and Human Trafficking Prevention Month in January 2016 [5]. This exhibition was free to visitors. Another organization, the Hope and Liberation Coalition (HLC), also presents traveling exhibitions of art therapy creations by human trafficking survivors throughout the year [6]. This group of Ohio art centers, artists, trafficking survivors, and others raises awareness and sells tickets to the events, giving the proceeds to anti-human trafficking programs. Well-known groups such as Save the Children and Human Rights Watch have also used art exhibits, such as the one by survivors of the war in Darfur, to raise awareness of human rights abuses [7, 8].

Such exhibits raise ethical questions about whether trafficking survivors are unintentionally being exploited by anti-trafficking advocates. In this essay, I examine the possible harms to trafficking survivors of displaying their therapeutic artwork, how such harms can be prevented, and the potential benefits of art therapy.

Art Exhibition as a Source of Harm?

Some groups that use human [trafficking survivors’ artwork](#) and stories to promote awareness have been accused of taking advantage of these survivors, attracting interest by drawing explicitly upon survivors’ painful experiences. For example, the journalist Scott Downman reported that an MTV documentary featuring trafficked children in Cambodia stereotyped and stigmatized the trafficked children and sensationalized the issue [9]. In instances like these, viewers are encouraged to see the survivors as stereotyped victims. Instead of sympathy and moral outrage moving the viewer to action, the viewer indulges dark pleasures. Images of people in pain, including emotional distress, humiliation, and even mild embarrassment, give viewers “a particular kind of pleasure, a glimpse at the disordered, frightening, repellent side of life” [10], an experience of *schadenfreude*. Gina Howard, for example, an advocate with HLC, states that due to the tendency of some media outlets to reduce human trafficking survivors’ complex and varied stories to sound bites, her organization “partners with media sources known for their compassionate, informed portrayal of trafficking survivors. Otherwise, trafficking survivors are less likely to be viewed as actual people with hopes, dreams and talents, and far more likely to be reduced to compilations of the abuses and violence inflicted upon them” (written communication, August 2016). Increased public stigma about trafficking survivors leads to reduction in quality of life through low self-esteem, unemployment, poorer health outcomes, and reduced well-being [11].

Other art installations have been accused of ethically problematic and possibly exploitative actions, though in different ways. Artist Guillermo Varga starved a dog to death in an art installation to protest a drug addict’s murder by two guard dogs. This

instigated the creation of other exhibitions by artists who also utilized shocking animal cruelty and death as “art” [12]. Photographer Jonathan Hobin used children to re-enact controversial or tragic events, such those that happened on September 11, 2001 and the death of Diana, Princess of Wales [13]. In these instances, the artists gained notoriety for utilizing subjects who experienced negative side effects and lacked control over their participation. Although trafficking survivors might seem to be making decisions of their own volition, they adapted and survived trafficking by allowing themselves to be dominated and manipulated. Unintentionally making decisions for trafficking survivors—which undermines their autonomy—can erode trust, result in “choices” made against their will, and increase trauma [14]. Justice requires equalization of power, which, in this case, can be gained through the survivors’ increased control over the display of their art and access to their story, thus preventing exploitation.

Trauma-informed training ensures that advocates understand the difference between autonomy and exploitation. [Trauma-informed care](#) (TIC) provides services in a welcoming and appropriate manner with an understanding of the biopsychosocial effects of trauma and minimizes re-traumatization [15]. “If you’re not informed about trauma, you can easily re-exploit someone. I believe strongly if you’re going to work in the anti-trafficking movement, you have an obligation to become trained in trauma-informed care,” says Margeaux Gray, a survivor and artist (oral communication, July 2016). According to Gray, this obligation extends to those working in any arena where violence occurs, such as intimate partner violence.

What these examples suggest is the ethical and clinical importance of considering how good intentions of organizations seeking to raise awareness about human trafficking actually play out for those whose work and traumatic experiences are on display for that purpose. Whether the artist experiences more harm or benefit from a survivor-focused art exhibit is the direct result of purposeful or incidental actions of the advocates working with them as well as the response of the viewing public.

Preventing Harm to Trafficking Survivor Artists

According to one study, women survivors of human trafficking develop significant rates of mental illness, with 35.8 percent suffering from PTSD with or without other disorders, 12.5 percent having depression without PTSD, and 5.8 percent having another anxiety disorder [16]. Male survivors suffer the same problems in smaller numbers [17]. The loss of choice that is fundamental to trafficking leads to a loss of sense of self [18]. This loss of self in turn leads to an inability to relate to the world, identify the source of pain and, in the end, heal. Beth Gherardi, the art therapist associated with HLC, explains, “Stripped of our humanity, our entire nervous system and ability to hold reality are compromised. The chaos and pain of this unraveling, this loosening and splintering of one’s sense of self and perception of the world, is at the core of trauma” (written communication, September 2016). Making choices enables survivors to gradually regain their realization

of power and of self. Common across publications and areas of practice is the idea that restoring choice is critical for survivor recovery [15]. Art therapists and exhibitors should thus work closely with survivor-artists to foster their sense of agency and control over their work. "Giving survivors options and choices and not be[ing] constrained in a box," is important, says Gray because "it lessens the chances of the survivor being re-exploited. Instead it gives the survivor an opportunity to be empowered and can assist them in their healing process" (oral communication, July 2016). She suggests that art installations give the artists as many choices as possible, even if it's only the placement of the artwork on the wall or what position the art should be displayed in.

Many survivors of abuse also have "victim sensitivity." People with victim sensitivity are sensitive to perceiving cues of untrustworthiness, even if the chance is small of a situation being exploitative, making them less likely to trust others and more likely to have suspicious thoughts and behave uncooperatively [19]. This can interfere with survivors' capacities to explore relationships with others, because the result of their reactions reinforces their negative expectations about others. People with victim sensitivity are also more likely to associate ambiguous social situations with injustice, and victim sensitivity is the strongest predictor of aggressive behavior [19]. Thus even groups that mean well can hurt the survivors' healing process if a perceived break in trust occurs. To promote trust, anti-trafficking organizations exhibiting survivors' artwork should encourage collaboration among survivors. Says Lyndsey Remarque, an artist, about Hope and Liberation Coalition, "Our group is run by artists, so we have all the control of the projects we do and where we exhibit" (written communication, August 2016).

Organizations seeking to promote awareness about human trafficking should bear in mind that people who have been traumatized by a relative or someone close to them are more vulnerable to adverse outcomes than those who lack close connections to the perpetrator of the traumatic experience [20]. Moreover, betrayal trauma—"when the people or institutions on which a person depends for survival significantly violate that person's trust or well-being" [20]—leads to more intense symptoms of PTSD, depression, and anxiety [20].

The Healing Power of Art for Trafficking Survivors

The art created by trafficking survivors and displayed in anti-trafficking exhibits facilitates artists' healing processes. A recent systematic review weakly supports [art therapy for trauma](#), largely due to a lack of research [21], but creative art therapies are recommended by the International Society for Traumatic Stress Studies [2].

Neurobiological theories propose that trauma interrupts communication between the verbal left hemisphere and the nonverbal right hemisphere and that, during recovery, the two hemispheres still have diminished communication [22]. This leads to alexithymia, the inability to identify and describe emotions. Art therapy helps survivors reassociate

experiences with words by facilitating a survivor's focus on creating visual representations (drawings, paintings, or sculpture, for example) about their experiences of trauma [22]. Gherardi explains, "For trafficking survivors, images and art making can speak for this place in them that is beyond words" (written communication, September 2016). Art therapy allows the right brain to produce a visual representation, then the left brain can state what is represented, allowing for what Gantt and Tinnin describe as "narrative closure, making the traumatic events past tense, imbuing nonverbal material with verbal description, and re-contextualizing fragmented experience" [23]. Proponents of this theory argue that this partnership between the left and right hemispheres is inherent in the process of making art and that art therapy recreates the partnership between the traumatized "emotional" brain and the "rational brain" [22]. Gray explains, "Sometimes it's hard to understand what I'm trying to say or an emotion I'm trying to put a name to, but it comes through in my art. It gives myself and others an opportunity to understand it from a different perspective" (oral communication, July 2016).

Creating art is also a way for survivors to feel that they matter as individuals. "During my trafficking it was a way to be heard," says Gray, "because I knew that saying anything was unacceptable, but when I created art, I heard my voice" (oral communication, July 2016). For survivors, art can help in the process of defining themselves and recovering a sense of [agency](#). "Art takes on an experiential role of helping survivors/children become themselves instead of being someone else. This understanding and appreciation of 'who you are' is essential to overcoming one's problems," says one youth outreach instructor who goes by the name "Art Lady" (written communication, August 2016). Enslavement and trafficking strip away victims' sense of identity and objectifies them; art therapy allows some of the survivors to rediscover a sense of self on their own terms.

Art therapy can also be done with several survivors, as a group session. Ellie Gardner, a psychology student and advocate working with Hope and Liberation Coalition, states, "If you do art with others, you create a deep bond, which is over and over again something survivors state they need. If you display art, you are vulnerable, but ... a powerful voice to tell your story ... is the pinnacle of becoming strong in [human trafficking] survival" (written communication, August 2016).

Some survivors who display their art publicly say that exhibiting their work has hastened their recovery. Gray says that knowing that her art touches people "makes a significant difference in my life" (oral communication, July 2016). Remarque, who displays at anti-trafficking exhibitions, states, "During our events we don't look to change the world, but we look to change the minds of the people in it. Art is a way to open a dialogue in people that sometimes they didn't know they had in them" (written communication, August 2016). By presenting their art in a public forum, receiving positive recognition from the community, and seeing anti-trafficking changes in the public environment, trafficking

survivors receive a benefit in addition to the healing they received through the art therapy itself.

Art Therapy as a Strategy for Bringing Sublimated Emotions to Conscious Levels of Awareness

Freud described sublimation, a psychological defense mechanism, as the ideal objective of any successful therapy, and sublimation can help explain the benefit of exhibiting one's art work [24]. In sublimation, unacceptable desires, feelings, or thoughts are transferred to a new activity that is not only less anxiety-provoking but also, perhaps, praised and valued by society [24]. Human trafficking survivors sometimes are so traumatized they cannot articulate their experiences to find healing, but "art therapy gives them a way to tell their stories without using language, instead using painting, drawing and poetry to develop a narrative about what has happened to them" [25]. One survivor, through multiple art therapy sessions, was empowered to tell her story through describing her art, stating, "This is an image symbolizing my unhappiness and sorrow at being trafficked and sold into prostitution" [26]. This conscious expression of experience previously not articulable is the ultimate goal of therapy. Art therapy has additional benefits, such as increasing resilience and anxiety management skills and realizing testimony and destigmatization [2].

There is a risk of criticism, but I believe those who attend these exhibitions of survivors' artwork are almost exclusively supporters who see the value in the strength shown by these artists. An example of possible sublimation of anger and other complex emotions is provided by Patty Wetterling, whose son was kidnapped in 1989 at the age of 11 by a sexual predator. She became a child safety advocate, and in 1994 Congress passed a law named after her son to establish sex offender registries [27].

Conclusion

To minimize risk of harm, including exploitation, to human trafficking survivors, I believe organizations should develop written protocols and make them available for use by anti-trafficking groups as the anti-trafficking movement grows. Large anti-trafficking organizations, in particular, should consider addressing guidelines for individual advocates or organizations to use. A main theme of these protocols should be giving survivor-artists choices about when and how to exhibit their work and allowing them to decide how much they participate. These protocols should also require training for all staff and advocates who interact with survivors about the nature and effects of current and lifetime trauma [15].

The fight against human trafficking needs advocates, and encouraging survivors to participate in a way that nurtures their healing could allow the movement to attract more survivors and partners. As Howard notes, "It is essential that ... 'we'—the public, charitable organizations and media sources—do not further add to the reduction of the

spirits and dignity of trafficking survivors who have already been exploited and reduced to mere commodities by traffickers" (written communication, August 2016).

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IMAGES OF HEALING AND LEARNING

Out of Darkness, Light: Drawing and Painting by Margeaux Gray

Artwork by Margeaux Gray, commentary and analysis by Mary Richards, MFA

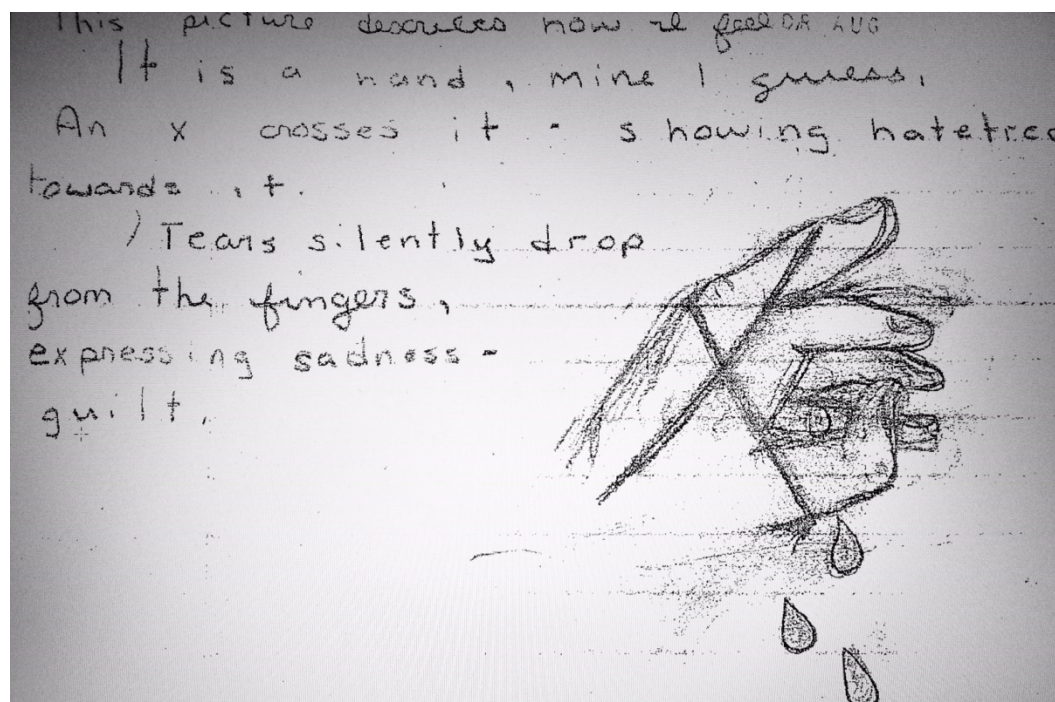


Figure 1. Detail of *Untitled*, by Margeaux Gray

Caption

Untitled was created by Margeaux Gray at the age of 13 during her time at a residential facility, prior to telling anyone about her abuse or that she was a victim of trafficking.

Analysis

This piece, which Margeaux Gray describes as a journal entry, is a raw, rare, and brave glimpse into suffering—a painful peering into a quiet self-loathing. The “x” crosses out, negates, appears to be constricting the hand. Gray explains she doesn’t know her own hand: “mine, I guess.” Disassociating from the body is likely a self-protective measure. Here she describes simply what she is able to see and feel: sadness, guilt.



Figure 2. Detail of *Universal Light, Nurture and Nursing*, by Margeaux Gray

Caption

Universal Light, Nurture and Nursing is a recent piece about which the artist states, "In my darkest moments, I saw a universal light." She uses found objects in her art to remind the viewer of the beauty and value of people our society might disregard or undervalue, among them victims of abuse, victims of human trafficking, and people with disabilities.

Analysis

There is a power that only some people know. It comes from an unimaginable darkness. Margeaux Gray's abstraction speaks to the magic of artistic alchemy, in which discarded

fragments are brought beautifully whole by merging a painterly, expressive quality. In a sense, Gray is symbolically putting the pieces back together through the work.

Margeaux Gray is a survivor of child abuse and sex trafficking. Today, she advocates against all forms of abuse by mentoring at-risk youth, speaking to the public, and talking to doctors and organizations about ways to improve health care and social services for victims. Margeaux uses her talent as an artist to convey the beauty and value of individuals who are often overlooked in today's society, among them victims of abuse, human trafficking, and those with disabilities.

Mary Richards, MFA, is an installation artist in St. Louis. She received her MFA from Ohio University and has worked as a gallery director and adjunct professor of art in the Washington, DC, and St. Louis areas for over a decade.

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SECOND THOUGHTS

Should US Physicians Support the Decriminalization of Commercial Sex?

Emily F. Rothman, ScD

Abstract

According to the World Health Organization, “commercial sex” is the exchange of money or goods for sexual services, and this term can be applied to both consensual and nonconsensual exchanges. Some nonconsensual exchanges qualify as human trafficking. Whether the form of commercial sex that is also known as prostitution should be decriminalized is being debated contentiously around the world, in part because the percentage of commercial sex exchanges that are consensual as opposed to nonconsensual, or trafficked, is unknown. This paper explores the question of decriminalization of commercial sex with reference to the bioethical principles of beneficence, nonmaleficence, and respect for autonomy. It concludes that though there is no perfect policy solution to the various ethical problems associated with commercial sex that can arise under either criminalized or decriminalized conditions, the Nordic model offers several potential advantages. This model criminalizes the buying of sex and third-party brokering of sex (i.e., pimping) but exempts sex sellers (i.e., prostitutes, sex workers) from criminal penalties. However, ongoing support for this type of policy should be contingent upon positive results over time.

Introduction

The term “commercial sex” is a depoliticized way to refer to sexual services that are exchanged for money or goods, also known as sex work or, in some cases, prostitution [1]. Commercial sex might involve consensual transactions or be the result of force, fraud, or coercion (i.e., trafficking, exploitation). The form of commercial sex also known as prostitution was widely tolerated in the US until the turn of the twentieth century, when feminists, Christians, and physicians united to oppose it [2]. In 1906, the *Journal of the American Medical Association* published an opinion that a full criminal ban on prostitution was the most appropriate solution to the mounting problem of venereal disease because experiments in government-regulated prostitution in Europe had failed [3]. Today the form of commercial sex also known as prostitution is a criminal activity in all 50 states, with the exception of some sparsely populated counties of Nevada, where it is legal in local government-regulated brothels [4].

In the contemporary discourse about commercial sex, the phrase “person who sells sex” or “seller” is used to refer to the person who provides the sexual service (i.e., prostitute), the “buyer” is the term used for the person purchasing sex (i.e., a john, customer), and “third-party broker” refers to the pimp, madam, or human trafficker who arranges the commercial terms of a sexual encounter between other people [1, 5-7]. In this paper, the term “seller” is used to describe all people who provide sexual services, whether they are consenting or not.

Despite global controversy about the regulation of commercial sex, there is widespread agreement that whether trafficked or not, sellers are at risk for a range of negative health and social consequences including homicide [8], physical assault [9], sexual assault [10], sexually transmitted infections (STIs) [11], and stigma [12, 13]. Trafficked and nontrafficked sellers are also at increased risk for substance misuse, posttraumatic stress disorder, and suicide [11, 14-20], and recent research has begun to explore the health consequences for children born to either consenting or trafficked sellers [21]. The risks of engaging in commercial sex are amplified for “street” sellers as compared to “indoor” sellers [9, 22] and, in the US, for people of color and transgender sellers [23, 24].

In this paper, the ethical considerations of changing the legal status of commercial sex in the US are considered in light of the several unknowns, including the percentage of commercial sex sellers who are trafficking victims or financially induced to sell sex and the lack of empirical information about the impact of decriminalizing commercial sex in the US context compared to other nations. The pros and cons of the four primary legislative choices—criminalization, legalization, decriminalization, and the Nordic model—are also explored.

Fundamental Ethical Problems in Commercial Sex Policy Decision Making

Commercial sex policy decision making must address a number of ethical problems. Here, we discuss three: understanding of consent, financial inducements, and vulnerability.

Defining sexual consent in commercial contexts. One pressing problem is that there are no trustworthy estimates of the percentage of sellers who sell sex willingly in the US or any nation. A seller may be doing so with (a) consent; (b) financially induced consent; (c) nonconsent because of force, fraud, or coercion by a third party (i.e., being trafficked); or (d) as a minor child, which in the US is automatically considered trafficking victimization [25]. There are numerous reasons why it’s virtually impossible to estimate the percentage of sellers who fall into each of these categories, a barrier that limits evidence-based decision making [26-28]. Moreover, the assumption that sellers can be classified under one of these four categories is predicated on the idea that a person either consents or does not consent to being a seller. A more nuanced perspective on the

concept of consent as it applies to commercial sex is that people might consent to a particular paid sexual encounter but not consent to specific sex acts that are forced upon them during that encounter. Whether people who engage sexually should be regarded as consenting or nonconsenting is important because opinions about decriminalization assume that most paid sexual encounters are entirely consensual from start to finish.

Understanding financial inducements. Amnesty International considers people “who live on the outskirts of society who are forced into sex work” to be consenting sellers because “it may be their only way to earn a living” [29]. The idea that financial inducements are inherently coercive, and thus exploitative, has been a central consideration in the debate about whether people should be permitted to sell their own organs [30]. Commercial sex has been referred to as “renting an organ” [31], which raises an ethical question: *For those living in poverty, are financial inducements to permit someone to have sexual access to their body inherently coercive, given that the sexual contact would be unwanted in the absence of payment and that they will receive no other benefit from the transaction?* According to Amnesty International, poverty does not necessarily undermine a person’s capacity to consent, which is a position at odds with the Belmont Report, which states that undue influence “occurs through an offer of an excessive, unwanted, inappropriate or improper reward or other overture in order to obtain compliance” [32].

Vulnerability. A related ethical problem is that there has been no consideration of the capacity of people who are cognitively or psychiatrically impaired, or intoxicated, to consent to paid sex. In medicine, it is accepted that there is heterogeneity in the capacity of people with psychiatric and cognitive disorders to consent to medical treatment or research [33, 34], and special protections are put in place to safeguard them. People with [psychiatric and cognitive disorders](#) also sell sex [35] and might even be overrepresented among sellers [36]. Some sellers also drink and use drugs and therefore might be impaired when negotiating paid sexual encounters. In fact, one strategy that traffickers use to subdue their captives is to force alcohol and other drugs on them [37]. Many US states now recognize that people’s sexual decision making can be impaired due to intoxication and that sex with a person too intoxicated to consent constitutes rape [38, 39]. Ethicists are needed, then, to help explore the question of whether it is possible for intoxicated people, or people with severe psychiatric and cognitive disorders, to consent to sell sex.

Policy Options for Addressing Commercial Sex

There are four main policy options for addressing commercial sex. The first option is criminalization, which means that buyers, sellers, and third-party brokers (“pimps”) can all be penalized. The second option is the criminalization of buying or brokering sex, but not selling it (the Nordic model). The third option is legalization, which is distinct from decriminalization because it entails some form of government regulation such as

requiring sellers' permits. The fourth option is [full decriminalization](#), which entails having no restrictions on commercial sex other than usual business laws.

Criminalization. The primary rationale for supporting this model is that it restricts the size of both the legal and illegal market and therefore should reduce trafficking, although the evidence to support this contention has been criticized [40-42]. Some form of criminalization appeals to those who are concerned that people who are economically dependent on paid sexual encounters have insufficient power to stop those encounters, or to object to aspects of them, once the encounters have been initiated and are therefore subjected to frequent sexual assault and rape. From this perspective, supporting some form of criminalization has the potential to reduce harm to those who are financially induced or coerced. It also appears that criminalization discourages buyers [43, 44], reducing the demand for sellers, which in turn worsens commerce for traffickers and reduces trafficking [45]. However, arrest can compound adversity for sellers, particularly those from [marginalized populations](#) [46], and enforcement can be selectively used against buyers and brokers [47] in a racist way. Criminalization can also create dangerous conditions in which sellers must collude with buyers and brokers to hide them from law enforcement [48]. On the whole, there appears to be little advantage to criminalizing the acts of both buyers and sellers.

The Nordic model. The Nordic model, which was first employed in Sweden, is now endorsed by the European Parliament. Although there is variation in how the Nordic model is implemented across countries [49], it is often promoted by those involved in anti-trafficking advocacy [50, 51]. Four separate studies have found that sex trafficking is reduced under this model [40, 41, 45, 52], and some analyses indicate that the Nordic model provides better support services to sellers than other systems [53, 54], although the results have been called into question [42, 48]. One criticism of the Nordic model is that any supposed benefit of legalizing selling is offset by the fact that buyers are still penalized, which means that sellers must continue to meet buyers under dangerous conditions [55]. However, this model has two potential advantages from the perspective of medical ethics. Sellers, including those who have been trafficked, receive many of the putative benefits of decriminalization—such as not being arrested or jailed—but the conditions discourage traffickers. The second advantage is that the model does not signal to the public that the commodification of sex is endorsed by the government. These advantages could appeal to physicians who want to balance the benefits and risks of state sanctions and try to cultivate more robust responses to patients they suspect are being trafficked.

Legalization. Under this model, either sellers or buyers or both parties can be required to obtain licenses, undergo health examinations, operate in specific zones, and comply with other restrictions. The theoretical benefits of legalization are that neither buyers nor sellers risk criminal penalty, but there are nevertheless strategies in place to control STI

transmission, improve sellers' safety, and quash trafficking. Primary objections are that trafficking increases [40, 45] and that sellers remain at unacceptably heightened risk of violence whether commercial sex is criminalized or legalized and may be harassed by government agents [56] and exploited by brokers [57]. Like criminalization, legalization is not clearly consistent with beneficence; complying with government regulation can be oppressively burdensome for individual sellers and the benefit to the community in terms of reduced STI transmission remains questionable, given that there is still too little evidence demonstrating conclusively that legalization is an effective method of preventing epidemics.

Decriminalization. This model is preferred by most sellers' political advocacy groups because it is the least restrictive and thus consistent with the principle of autonomy [58]. For example, the World Health Organization (WHO) and Amnesty International have taken the position that every nation in the world should repeal or refrain from introducing any law that criminalizes any aspect of consensual commercial sex between adults, irrespective of local conditions [6, 29]. It should be noted, however, that sellers have diverse opinions about regulation [59, 60]. The primary arguments in favor of decriminalization are that it reduces HIV and other sexually transmitted infections by reducing violence and enabling more consistent condom use [61, 62], offers sellers police protection [63], reduces stigma, could afford sellers employment benefits such as sick leave and workers' compensation [64], and realizes the rights of adults to choose to sell sex. Some have also argued that decriminalizing commercial sex may improve consensual sellers' ability to aid trafficking victims whom they meet in commercial sex venues [58]. However, counter to expectations, the decriminalization or legalization of commercial sex in New Zealand, the Netherlands, and Germany has not resulted in uniformly safer conditions [65, 66], successful seller unions [64], destigmatization [67], reduced trafficking victimization [68], or substantially increased seller satisfaction [66]. Moreover, countries where commercial sex is not criminal appear to experience higher trafficking inflows, according to economists' analyses [40, 69]. An additional concern is that from a social norms perspective, it is not yet clear if decriminalization increases the public's moral disengagement, exacerbates the sexual objectification of people, or counteracts efforts to educate the public about the importance of consent during sexual encounters. Because these effects could increase health disparities, these possibilities are important to investigate.

Conclusion

Although paternalistic approaches in matters of public health are always controversial, it has been argued that "too little state intervention in the cause of improving population health can violate individuals' rights, just as too much can" [70]. On the question of decriminalizing the form of commercial sex known as prostitution in the US, the potential harms to individuals and the public must be considered as carefully as the benefits of the expansion of individuals' rights. The commercial sex criminalization and legalization

models seem largely inconsistent with the principles of beneficence, nonmaleficence, and autonomy, because these policies disempower and burden sellers. Moreover, support for decriminalization could be inconsistent with the principle of nonmaleficence if it encourages trafficking and puts vulnerable people at increased risk for harm. The Nordic model, though imperfect, offers the advantage of eliminating punishments for sellers while potentially preventing the expansion of the commercial sex market and limiting the number of people trafficked. If new commercial sex policies of any type are enacted in US states, rigorous evaluation of their impact will be critically important and should be the basis for future decision making.

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SECOND THOUGHTS

Decreasing Human Trafficking through Sex Work Decriminalization

Erin Albright, JD, and Kate D'Adamo, MA

Abstract

In order to decrease human trafficking, health care workers should support the full decriminalization of prostitution. Similar to trafficking in other forms of labor, preventing trafficking in the sex trade requires addressing the different forms of marginalization that create vulnerable communities. By removing punitive laws that prevent reporting of exploitation and abuse, decriminalization allows sex workers to work more safely, thereby reducing marginalization and vulnerability. Decriminalization can also help destigmatize sex work and help resist political, social, and cultural marginalization of sex workers.

Introduction

In August 2016, Amnesty International, while maintaining and reaffirming its strong condemnation of human trafficking, released a model policy that calls upon countries to decriminalize the sex trade in order to better protect the health and human rights of sex workers [1]. As Amnesty explains in the policy, decriminalization is the shift from “catch-all offences that criminalize most or all aspects of sex work,” including laws that target noncoercive third parties who purchase or facilitate sex work, to “laws and policies that provide protection for sex workers from acts of exploitation and abuse” [2]. The policy has been supported by the World Health Organization, UNAIDS, the Global Alliance Against Traffic in Women (GAATW), Human Rights Watch, Lambda Legal, the American Civil Liberties Union, Freedom Network USA, and numerous other organizations that focus on vulnerable populations, including victims of human trafficking [3, 4]. Most importantly, it is a policy overwhelmingly supported by those trading sex—the community impacted by these laws and policies [5].

In contrast, organizations that view decriminalization as granting permission and impunity to would-be exploiters have criticized the policy, despite its insistence that anti-trafficking and physical and sexual assault laws be maintained or established [1]. These criticisms, however, fail to engage in a nuanced conversation of sex work as it relates to exploitation, poverty, discrimination, worker rights, and human trafficking [6]. More importantly, research shows the opposite to be true—that it is *criminalization* that creates conditions of impunity and enhances sex workers' vulnerabilities to violence and exploitation, including trafficking.

Reasons to Oppose Criminalization of Sex Work

Sex work and sex trafficking are not synonymous. Involvement in the sex trade occurs across a constantly shifting spectrum of choice, circumstance, and coercion. Victims of trafficking are at the far end of this spectrum, involved through force or coercion. While quantifying the number of persons trafficked into the sex trade is difficult, as we discuss below, we do know that criminalization of sex work increases sex workers' vulnerability to violence, exploitation, and [trafficking](#) [7]. So, here, we discuss four reasons why health care professionals should oppose the criminalization of sex work.

Increased violence. First, criminalization increases opportunities for violence that's *de facto* unreportable [7]; that is, because the work they do is regarded as criminal activity, sex workers are easy targets for abuse and exploitation, including trafficking. Fear of arrest and other consequences means that those engaged in sex work are less likely to report instances of violence or exploitation, resulting in a "climate of impunity [that] emboldens police, health sector, and non-state groups to abuse sex workers' rights" [8]. This is true even for so-called "partial criminalization" frameworks, such as those that penalize only the buyers of sex. Although such a strategy appears at first glance to be grounded in the well-being of sex workers, implementation often means policing of the areas where sex workers conduct business. This forces those working into more isolated conditions and locations, increasing their physical vulnerability. It disrupts critical safety strategies and negotiations including harm-reduction techniques—such as the use of condoms—and peer networks [7]. According to a study published in the *Lancet*, partial criminalization "creates harms similar to those of full criminalisation by impeding sex workers' ability to protect their health and safety, and creating an antagonistic relationship with law enforcement resulting in a climate of impunity" [8].

Erosion of trust. Second, criminalization [undermines trust](#) in support systems, including health care. Fear of judgment, discrimination, lower quality of service, and legal consequences inhibit many from disclosing that they are involved in sex work, regardless of whether they are so engaged through choice, circumstance, or coercion [9]. One study of 783 sex workers reported that 70 percent had never disclosed the nature of their work to a health care professional [10]. In a needs assessment of sex workers who seek clients in public spaces, often referred to as street-based sex work, one woman explained, "I was raped and was afraid to be judged by the hospital and that they'd call the police" [9]. Disrupting the relationship between a health care professional and a sex worker can mean important red flags for exploitation, violence, and trafficking go unreported.

Increased vulnerability. Third, involvement in the criminal justice system creates long-lasting consequences, in terms of a person's health outcomes and vulnerability to trafficking and other forms of exploitation. The inability to hide an arrest and conviction

for prostitution makes obtaining formal employment, housing, benefits, and community support significantly more difficult. Fines, fees, and costs associated with an arrest exacerbate poverty, which significantly increases a person's vulnerability to trafficking and other forms of exploitation.

Stigma. Finally, criminalization reinforces stigma, which perpetuates sex workers' marginalization. Research supports the fact that sex workers are some of the most marginalized people in the world, subject to widespread human rights violations including homicide, physical and sexual violence, incarceration, harassment from law enforcement, and discrimination in accessing health care and other sources of support [1]. Socially, culturally, politically, and economically, sex workers are stigmatized, ignored, and actively silenced even in advocacy spaces debating the very policies that influence their lives [11]. Too often, sex workers are spoken for instead of given a platform for speaking themselves, and a result is a lack of recognition and enforcement of their basic human rights.

Conclusion

Decriminalization can motivate more prominent recognition of sex workers' [human rights](#) and is thus a critical mechanism for decreasing trafficking. When we improve the health and human rights of sex workers, we do so for those who are trafficked into sex work as well. Indeed, the United Nations Office of the High Commissioner for Human Rights "Recommended Principles and Guidelines on Human Rights and Trafficking" notes that "violations of human rights are both a cause and a consequence of trafficking in persons," and therefore it is "essential to place the protection of all human rights at the centre of any measures taken to prevent and end trafficking" [12]. By decriminalizing sex work, sex workers who experience violence can seek help from law enforcement, health care workers, or even friends with less fear of consequences to themselves or others. They can engage peer networks and employ harm-reduction techniques that help keep them safer, such that they no longer have to face the consequences of a criminal record for simply trying to survive.

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Abigail English, JD, is director of the Center for Adolescent Health & the Law in Chapel Hill, North Carolina. From 2012-2013, she served on the Institute of Medicine and National Research Council Committee on Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States. Her research and advocacy have focused on health insurance and public financing of care, consent and confidentiality protections,

and sexual and reproductive health care. Her recent work has addressed human trafficking of the young and vulnerable.

Margeaux Gray is a survivor of child abuse and sex trafficking. Today, she advocates against all forms of abuse by mentoring at-risk youth, speaking to the public, and talking to doctors and organizations about ways to improve health care and social services for victims. Margeaux uses her talent as an artist to convey the beauty and value of individuals that are often overlooked in today's society, among them victims of abuse, human trafficking, and those with disabilities.

Anna Gribble, MSW, MPH, is an ORISE Fellow at the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion in Rockville, Maryland. Ms. Gribble is a public health social worker dedicated to improving the health care system through a trauma informed and patient centered lens. Previously, she has worked closely with HEAL Trafficking on the development of a human trafficking protocol toolkit for health care professionals and with Dr. Hanni Stoklosa at Brigham and Women's Hospital on improving care for survivors of trafficking.

Patrick L. Kerr, PhD, is a clinical psychologist and an associate professor in the Department of Behavioral Medicine and Psychiatry at West Virginia University (WVU) School of Medicine- Charleston, where he directs the WVU Dialectical Behavior Therapy Services Program. He also serves as a member of the West Virginia Human Trafficking Task Force. His research and clinical interests include suicidal behavior, non-suicidal self-injury, and mood disorders, and traumatic stress.

Marti MacGibbon, CADC-II, ACRPS, is an inspirational speaker and author and an expert on trauma resolution and addiction. She uses her personal story to raise awareness of, and strip away stigma from, human trafficking, domestic violence, addiction, PTSD, and homelessness. As a human trafficking survivor leader and advocate, Ms. MacGibbon has lobbied and shared her expertise at the White House, US Department of State, and the California State Legislature.

Wendy L. Macias-Konstantopoulos, MD, MPH, is a board-certified emergency physician at Massachusetts General Hospital (MGH) in Boston, where she is also a faculty member in the MGH Department of Emergency Medicine's Division of Global Health & Human Rights, co-founding director of the Human Trafficking Initiative, and founding medical and executive director of the MGH Freedom Clinic, an innovative primary care clinic that provides comprehensive health care for human trafficking survivors. She is an assistant professor of emergency medicine at Harvard Medical School and has served as a subject matter expert for the US Department of Health and Human Services, conducted research, provided media interviews, published, and lectured widely on the topic of health and human trafficking.

Olivia F. Mittel, MD, MS, is assistant dean for medical student affairs and assistant professor of pediatrics at the University of Louisville School of Medicine in Louisville, Kentucky. Dr. Mittel earned a certificate in medical education from Stritch School of Medicine at Loyola University, Chicago and a Human Rights Award from the Kentucky Division of the United Nations Association for her work educating health care professionals about human trafficking.

Monir Moniruzzaman, PhD, is an assistant professor in the Department of Anthropology and Center for Ethics and Humanities in the Life Sciences at Michigan State University in East Lansing, where he regularly teaches the course, Social Contexts of Clinical Decision. His research examines human organ trafficking through the narratives of kidney and liver sellers from Bangladesh and has been published in major journals, presented at the US Congress Human Rights Commission, and transformed into art exhibits.

Rikki E. Morris, DO, is an international emergency medicine fellow at SUNY Downstate Medical Center in New York City and expects to complete a master's degree in public health in 2017. She is currently developing international emergency medicine projects in both Ecuador and Haiti. Her areas of interest include international emergency medicine, global public health, and reproductive health.

Clydette Powell, MD, MPH, serves as the director of the Division of Health Care Quality within the Office of the Assistant Secretary of Health at the US Department of Health and Human Services in Washington, DC. She is also an adjunct associate professor of pediatrics at The George Washington University School of Medicine and Health Sciences. Dr. Powell has provided direct services to persons who have been trafficked and has also published in the field of human trafficking and was a presenter at the first HHS Symposium on Human Trafficking in 2008.

Mary Richards, MFA, is an installation artist in St. Louis. She received her MFA from The Ohio University and has worked as a gallery director and adjunct professor of art in the Washington, DC, and St. Louis area for over a decade.

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Hanni Stoklosa, MD, MPH, is executive director of HEAL Trafficking and an emergency physician at Brigham and Women's Hospital with appointments at Harvard Medical School, Harvard T.H. Chan School of Public Health, and the Harvard Humanitarian Initiative. She is a researcher, advocate, and speaker focusing on the public health of trafficking survivors in the US and internationally. She has advised the US Department of Health and Human Services, US Department of Labor, and National Academy of Medicine on issues of human trafficking and testified as an expert witness multiple times before the US Congress.

Joseph Stoklosa, MD, is an instructor in psychiatry at Harvard Medical School in Boston. He is also the assistant program director for the MGH/McLean Adult Psychiatry Residency Training Program and the clinical director of McLean Hospital's Psychotic Disorders Division.

Jonathan Todres, JD, is a professor of law at Georgia State University College of Law. His research focuses on children's rights issues. He has authored numerous publications on child trafficking and related forms of child exploitation.