

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
<p>“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.</p>	<p>Understands the widespread impact of trauma.</p>	<p>Being attentive to others’ needs, goals, risks, and vulnerabilities requires understanding the impact of their trauma.</p>

<p>“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.</p>	<p>Recognizes the signs and symptoms of trauma.</p>	<p>Assuming responsibility for improving the condition of others requires recognition of the signs and symptoms of their conditions.</p>
<p>“Care giving” is the actual delivery of care with competence such that it is appropriate and effective quality care.</p>	<p>Responds by fully integrating knowledge about trauma into policies, procedures, and practices.</p>	<p>Delivering appropriate and effective care competently requires comprehensively responding to needs, goals, risks, and vulnerabilities in all aspects of care.</p>
<p>“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.</p>	<p>Seeks to actively resist retraumatization.</p>	<p>Ensuring that care is responsive to needs, goals, risks, and vulnerabilities requires actively seeking to avoid potential shortcomings of care such as retraumatization.</p>

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.

References

1. Zimmerman C, Hossain M, Yun K, et al. The health of trafficked women: a survey of women entering posttrafficking services in Europe. *Am J Public Health*. 2008;98(1):55-59.
2. Oram S, Stöckl H, Busza J, Howard LM, Zimmerman C. Prevalence and risk of violence and the physical, mental, and sexual health problems associated with human trafficking: systematic review. *PLoS Med*. 2012;9(5):e1001224. <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001224>. Accessed September 12, 2016.
3. Lederer LJ, Wetzel CA. The health consequences of sex trafficking and their implications for identifying victims in healthcare facilities. *Ann Health Law*. 2014;23(1):61-87.
4. Kiss L, Pocock NS, Naisanguansri V, et al. Health of men, women, and children in post-trafficking services in Cambodia, Thailand, and Vietnam: an observational cross-sectional study. *Lancet Glob Health*. 2015;3(3):e154-e161.
5. Turning pain into power: trafficking survivors' perspectives on early intervention strategies. Family Violence Prevention Fund. <http://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/Turning%20Pain%20intoPower.pdf>. Published 2005. Accessed September 1, 2016.
6. Chisolm-Straker M, Baldwin S, Gaïgbé-Togbé B, Ndukwe N, Johnson PN, Richardson LD. Health care and human trafficking: we are seeing the unseen. *J Health Care Poor Underserved*. 2016;27(3):1220-1233.
7. Baldwin SB, Eisenman DP, Sayles JN, Ryan G, Chuang KS. Identification of human trafficking victims in health care settings. *Health Hum Rights*. 2011;13(1):e36-e49.
8. Macias-Konstantopoulos WL, Munroe D, Purcell G, Tester K, Burke TF, Ahn R. The commercial sexual exploitation and sex trafficking of minors in the Boston metropolitan area: experiences and challenges faced by front-line providers and other stakeholders. *J Appl Res Child*. 2015;6(1):4. <http://digitalcommons.library.tmc.edu/cgi/viewcontent.cgi?article=1242&context=childrenatrisk>. Accessed November 21, 2016.
9. Macias-Konstantopoulos W, Bar-Halpern M. Commercially sexually exploited and trafficked minors: our hidden and forgotten children. In: Parekh R, Childs EW, eds. *Stigma and Prejudice: Touchstones in Understanding Diversity in Healthcare*. Cham, Switzerland: Springer International; 2016:183-202.

10. Whitbeck LB, Chen X, Hoyt DR, Tyler KA, Johnson KD. Mental disorder, subsistence strategies, and victimization among gay, lesbian, and bisexual homeless and runaway adolescents. *J Sex Res.* 2004;41(4):329-342.
11. Christensen TM. Trafficking for sexual exploitation: victim protection in international and domestic asylum law. United Nations High Commissioner for Refugees. <http://www.unhcr.org/en-us/research/working/4d9c7c869/trafficking-sexual-exploitation-victim-protection-international-domestic.html>. Published April 2011. Accessed September 1, 2016.
12. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 7th ed. New York, NY: Oxford University Press; 2013.
13. Mosley C. The language we use: victim and survivor. *We End Violence*. June 4, 2013. <http://www.weendviolence.com/blog/2013/06/04/the-language-we-use-victim-and-survivor/>. Accessed October 2, 2016.
14. Alpert EJ, Ahn R, Albright E, Purcell G, Burke TF, Macias-Konstantopoulos W. Human trafficking: guidebook on identification, assessment, and response in the health care setting. Massachusetts General Hospital; Massachusetts Medical Society. [http://www.massmed.org/Patient-Care/Health-Topics/Violence-Prevention-and-Intervention/Human-Trafficking-\(pdf\)/](http://www.massmed.org/Patient-Care/Health-Topics/Violence-Prevention-and-Intervention/Human-Trafficking-(pdf)/). Published 2014. Accessed August 20, 2016.
15. Macias-Konstantopoulos W. Human trafficking: the role of medicine in interrupting the cycle of abuse and violence. *Ann Intern Med.* 2016;165(8):582-588.
16. Clawson HJ, Dutch N. Identifying victims of human trafficking: inherent challenges and promising strategies for the field. US Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/sites/default/files/pdf/75321/ib.pdf>. Accessed September 1, 2016.
17. Elliott DE, Bjelajac P, Fallot RD, Markoff LS, Reed BG. Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women. *J Community Psychol.* 2005;33(4):461-477.
18. Child Welfare Information Gateway. Mandatory reporters of child abuse and neglect. <https://www.childwelfare.gov/pubPDFs/manda.pdf>. Accessed November 7, 2016.
19. Durborow N, Lizdas KC, O'Flaherty A. Compendium of state statutes and policies on domestic violence and health care. Family Violence Prevention Fund. http://www.acf.hhs.gov/sites/default/files/fysb/state_compendium.pdf. Published 2010. Accessed October 2, 2016.
20. Bodenheimer T, Pham HH. Primary care: current problems and proposed solutions. *Health Aff (Millwood)*. 2010;29(5):799-805.

21. Beck ME, Lineer MM, Melzer-Lange M, Simpson P, Nugent M, Rabbitt A. Medical providers' understanding of sex trafficking and their experience with at-risk patients. *Pediatrics*. 2015;135(4):e895-e902.
22. Hurt CB, Eron JJ Jr, Cohen MS. Pre-exposure prophylaxis and antiretroviral resistance: HIV prevention at a cost? *Clin Infect Dis*. 2011;53(12):1265-1270.
23. Tronto JC. *Moral Boundaries: A Political Argument for an Ethic of Care*. New York, NY: Routledge; 1994.
24. Substance Abuse and Mental Health Services Administration. Trauma-informed approach and trauma-specific interventions. <http://www.samhsa.gov/nctic/trauma-interventions>. Updated August 14, 2015. Accessed September 1, 2016.

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