Clinical Story

You are seeing a refugee family from the Shimelba Refugee Camp in Ethiopia. Ethnically the family is Tigrinyan and they used to live in Eritrea. They have been in the refugee camp for the last 6 years, and have migrated to the U.S. 2 months ago. You are unfamiliar with the location of Eritrea, why there are refugees in Ethiopia, and who the Tigrinyan people are. You ask routine questions through an interpreter and learn that the mother finds your questions very funny and isn’t sure why you are asking them. You receive many laconic answers: yes, no, it’s ok, etc. The Tigrinyan woman further says, “But, he can ask whatever he wants, he’s a doctor.”

With the Tigrinyan mother’s permission to be more inquisitive, you ask some dietary questions and discover that her 18mo is drinking milk, but she has no idea what kind (goat’s, cow’s, whole milk, skim milk, etc). She further tells you that they shop at one small grocery store only and eat very little as they are unfamiliar with our food, how to use a stove and oven, and how to prepare the food. She has also heard from some of her friends that because her rent will no longer be covered after 3 months in the U.S., she will have to start selling her food stamps to help pay for her $800 monthly rent. She has been unable to find a job, and her case worker does not answer the phone when she calls. Upon blood testing, the children are found to be nutritionally deficient.

You ask the mother of the family if her 15yo son has had any traditional cultural treatments. She responds no, but during your physical examination you notice 5 discrete large oval scars in an arch on his upper chest and three more lesions on his upper back. Through the interpreter, you ask, “What are these marks from?” The mother responds, “Those are from a cultural treatment he had when he was a young child.” You wonder why she didn’t tell you about them the first time you asked.

The Tigrinyan Mom describes her current living conditions in Aurora as very poor with many rats and 3 different types of insects, and that the insects eat their food. She does not understand how to use the bus or public transportation in general. She has been told through an interpreter that the school is worried that her children smell badly and that they are wearing the same pajamas to school every day. She expresses to you that her culture does not smell, but she does not have soap, shampoo, laundry detergent or many other things that food stamps will not pay for. Her children don’t have enough clothes, let alone clothes that fit them. She is also not sure where to go or what to do during her days, and the family spends a lot of their time indoors at their apartment.

Introduction

According to the 1951 United Nations Refugee Convention, a refugee is defined as someone who “owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country...” 1

The Refugee Health Elective II (RHII) is a clinical elective in the Department of Internal Medicine, under Dr. Jamal Moloo. It follows the Refugee Health Elective I, which is run by Dr. Paritosh Kaul in the first two years of medical school. RHII takes place primarily at the Colorado Refugee Wellness Center in Aurora, which performs medical screenings for arriving refugees to Colorado within 3 months of arrival. The students work closely with the clinic’s staff to complete medical screenings, which include a medical interview, a physical exam, and a mental health screening. They review the patient's chart and follow up on overseas reports and laboratory testing.

In recent years the national annual admissions levels for refugees has been set at 76,000 persons. In 2012, Colorado accepted 1,797 refugees, which ranked 10th among the states. The countries of origin with the largest incoming populations of refugees in Colorado included Iraq (16.8%), Bhutan (15.0%), and Myanmar (14.9%). Other large groups represented include Eritreans and Somalis. Arapahoe County accounted for 32.8% of residency for new refugees, while Adams County (27.9%) and Denver County (22.2%) also accepted large populations. ii

The refugee population is faced with many challenges with assimilation to our communities. It is inhumane to leave this vulnerable population without assistance and guidance. In the following pages, I demonstrate how the values of culturally effective care can be used to structure a curriculum for medical students.
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**Eritrea**
Border wars and conflict between Ethiopia and Eritrea caused resettlement of many ethnic Tigrinya and Kunama from Eritrea to the Shimelba Refugee Camp in Ethiopia in order to escape compulsory conscription into the Eritrean national service and persecution by the Eritrean government respectfully. 

**Bhutan**
97% are ethnically Nepalis who migrated to southern Bhutan in the late 1800s and were labeled as Lhoutsampa (people of the south). In 1980s, Bhutan’s king became worried about growing Nepalese population in Bhutan and adopted a series of policies called Bhutanization to unify the country under the Druk culture. Nepalese were stripped of their citizenship and civil rights, and ~100,000 now reside in refugee camps in Nepal. Nepalese refugees will have very limited knowledge of urban amenities and life in the West, and most will not be familiar with modern cooking appliances and practices. Arranged marriage, traditional medicine, and occasionally polygamy are a part of the culture. 

**Iraq**
After the creation of an Iraqi state early in the 20th century, Iraqis developed a common identity. Over the last 2 decades, as the result of recent wars and their aftermath, sectarian, tribal, and ethnic identities have become central to a person’s social identity. Due to cultural clashes and violence, an estimated 2 million Iraqis have taken refuge in neighboring countries, mostly in Syria and Jordan. Cultural identity has become more fragmented in Iraq. One commonality remains: universal belief that everything depends on will of God, a belief that contrasts sharply with American notion that people are masters of their own destiny. 

**Somalia**
Military dictatorship from late 1960s to 1991 under Siyaad Barre. Coup and civil war since 1991, with fragmentation of the country into different states. Culturally, they are traditionally nomadic, tribal people who practice Islam. Al-Shabaab, a cell of Al Queda, is a militant jihadist group in the country that gained a foothold in the country. Female circumcision common. Planned weddings with dowries are common. Refugee camps are in Uganda & Kenya. 

**Myanmar (Burma)**
Anthropologists have counted 8 main ethnic groups, and 130 distinctive subgroups. In 1962, Ne Win seized control of the government and imposed a strict military rule. In the 1980s, he launched the Burmese Way to Socialism. His economic policies had devastating effects, and on 08/08/1988, an uprising occurred that was violently shut down by the army. Ne Win stepped aside and a group of military generals rule the country now in an oppressive strict police like state, known as the State Peace and Development Council. The largest group of refugees is ethnically Karen. Some subgroups of Karen use brass rings around the neck, a great sign of beauty. Refugees arriving from urban experience in Thailand or Malaysia will adapt more quickly to American housing, while those coming from camps where life in bamboo houses did not include electricity, plumbing, or telephones have more challenges.
Curriculum

The ACGME defines curriculum as “a formal educational plan based on results of a needs assessment, and including goals and objectives developed to meet the needs identified, educational activities through which the plan is implemented, and evaluation of the plan with feedback to provide continued improvement in the educational process.” The RHII elective is designed to meet these curricular requirements, with congruence between the needs assessment, broad goals, specific learning objectives, educational activities, and evaluation (Please see Dr. Treitz previous newsletter on curriculum).

Needs Assessment

Meetings with medical students interested in refugee health revealed that they have little opportunity to practice communication with interpreters, reflect on cultural interactions and negotiation, or gain exposure to maladies uncommon in the U.S. such as nutritional deficiencies, TB, and worm infections. Meetings with the head of the cultural effectiveness medicine thread in the medical school (Dr. Paritosh Kaul) helped elucidate how the curriculum could best complement existing medical student experiences. A literature review revealed no previous published clinical refugee health electives. Meetings with the medical head of the clinic also ensured that the medical needs of the patients and the clinic were complemented so as to maximize service learning.

Goals and Objectives

To care for refugee patients in a comprehensive manner, it is important to communicate with them effectively and to understand their unique cultural perspective. The broad goals of RHII are for students to:

1. Recognize health conditions that are unique to the refugee population.
2. Describe the perspectives of refugees who are adjusting to life in Colorado.
3. Enumerate the social/legal, cultural, and economic barriers to health for refugees.

Based on the needs assessment, specific Learning Objectives in 4 domains (Clinical Care, Social Circumstances, Legal Circumstances, and Cultural Effectiveness) were established that will help the student achieve the curriculum goals. These are specific and measurable expectations that a student must accomplish by the end of the rotation.

For example:

1. The student will describe the health care process of the refugee before their departure from their home country including:
   a. Describe Panel Physicians and the goal of overseas examination.
   b. Describe Class A and Class B medical conditions.
   c. Describe the role of the Centers for Disease Control and Prevention (CDC) and the Division of Global Migration and Quarantine (DGMQ).

Each learner has a worksheet to fill out during the rotation that helps them identify answers to questions that directly correlate with the learning objectives. This helps the learner focus on specific information that should be gleaned during their rotation. Each question also correlates directly with the retrospective pre and post self-evaluation and quiz that are used to evaluate the curriculum at the end of the rotation.


**Educational Activities**

The syllabus contains readings and recommendations for websites that give the student access to the knowledge in all domains that needs to be ascertained during the rotation.

**Clinical Care:**
By the end of the rotation, the students should be able to describe the health care process of refugees before departure in their home country. This knowledge content relies heavily on readings in the syllabus, including websites. An example of their correlate worksheet question in this domain is:

Describe Panel Physicians and the goal of the overseas examination:

The students observe intakes on refugees with a mental health professional, employed by the Colorado Department of Health and Environment. Students do medical histories and physical examinations with refugee patients, and review their charts under the supervision of medical staff familiar with the process, with the hope that most or all of the learning objectives will be reinforced in the clinical setting, providing planned redundancy in different teaching modalities. This experience addresses the second clinical care learning objective, which is to describe the health considerations for newly arrived refugees in the U.S. including listing the CDC recommended screening tests, etc.

The medical students work with interpreters frequently during the rotation and have readings and resources that discuss the principles of using a medical interpreter effectively. The Refugee Health II curriculum is designed to teach the learner to choose words carefully, taking extra time to make sure that their questions are understood in the way that they mean in hopes of collecting the information that is needed. In addition, the syllabus highlights that communication is also non-verbal, and that careful attention should be paid to understanding what message our tone, facial expression, and body language convey. For example, in the Burmese culture(s), elderly persons are treated with respect, and it is important to give or receive something from elders using both hands. In addition, it is considered disrespectful to point your feet toward a senior person, as they are considered the least noble part of the body.

**Social Circumstances:**
Housing is a difficult situation for refugees after arrival in Colorado. Their housing is meager and scantly supplied with used dilapidated furniture. Three months after arrival, they are required to pay rent themselves. Furthermore, it is difficult for them to find jobs. Students have the opportunity to make a home visit with a volunteer agencies in order to gain first hand exposure to the living circumstances of this unique population. In addition to readings that are congruent to the learning objectives, students observe Colorado Department of Health and Environment resource experts (including one employee who was once a refugee herself) giving recommendations to refugees, including connecting them with social resources (eg, food stamps), a primary care physician, a dentist, and schooling.

**Legal Circumstances:**
The Refugee Health Elective II includes a one day experience at the CU Law School in collaboration with Dayna Bowen Matthew, JD, during which they receive didactics on legal aspects of refugee health congruent with specific learning objectives, and observe a clinical trial.

**Cultural Effectiveness:**
In addition to reading resources, students are given the opportunity to speak with and learn from health navigators (including doing a home visit), interpreters, volunteer agencies (including doing picking up of a refugee family at the airport), and the Colorado Department of Public Health and Environment. The syllabus has targeted readings to introduce many of the refugee cultures, and other readings targeted at equipping the students with tools to accomplish culturally effective care, such as Arthur Kleinman’s seminal paper in 1978, in which he describes a tool to elicit a patient’s explanatory model of their health condition.

The tool consists of asking 8 patient-centered questions:

1. What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a short or long course?
6. What kind of treatment do you think the patient should receive?
7. What are the most important results you hope to receive from this treatment?
8. What are the chief problems the sickness has caused?
9. What do you fear most about the sickness?

For example, in a report written by the CDC, it is observed that Bhutanese refugees often use home remedies or traditional healers as first-line treatment for illness and seek outside medical advice only if their symptoms are not relieved. Patients may need encouragement and positive reinforcement to feel comfortable sharing their use of traditional practices with American providers. Kleinman’s tool helps reveal these cultural explanations and treatments.
Evaluation

Adult learning theory states that adults are self-motivated to learn. Evaluation is best thought of as an evaluation of the rotation, not an assessment of the learners. Worded differently, it is a way to determine whether or not you have taught the learner what you targeted that they would learn. There are several different evaluation tools used in the RHII elective:

1. A self-assessment tool called a retrospective pre-rotation and post-rotation self-evaluation (validated for other topics and discussed in the literature) is done, in which the learner rates themselves on their ability before and after the rotation.

For example:

<table>
<thead>
<tr>
<th>Prior to the Refugee II Elective, I was able to:</th>
<th>After the Refugee II Elective, I can:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No</td>
<td>• No</td>
</tr>
<tr>
<td>• Partially</td>
<td>• Partially</td>
</tr>
<tr>
<td>• Yes</td>
<td>• Yes</td>
</tr>
</tbody>
</table>

2. In order to validate or refute these findings, a quiz that is congruent with each learning objective and retro pre and post self-evaluation is then given to the student.

For example:

Describe a panel physician

3. Students are required to write a one-page reflection paper on how culturally effective their care was and how it was challenging to achieve this.

4. Lastly, students are required to have one written observation completed weekly. The written observation is a modified RIME evaluation tool with a brief cover letter that asks the observer to comment on the student’s ability to communicate clearly with the refugee, and to comment on how culturally effective their care is.

These evaluation tools are then used to guide changes in curriculum content, implementation, or educational activities moving forward.

Helpful Websites

- CO Health Equity Project - coloradohealthequity.org
- CO Refugee Services - colorado.gov
- Migrant Health Resources - cdc.gov
- Canadian Guidelines - cmaj.ca
- Canadian Refugee Website - kidsnewtocanada.ca
- Migrant Health Guide - hpa.org.uk
- International Office for Migration - iom.int
- AAMC guide to interpreter - aamc.org
- Ethno Med - ethnomed.org
- Cultural Orientation - culturalorientation.net
- Health Info Translations - healthinfotranslations.org
- Healthy Roads Media - healthyroadsmedia.org
- Diversity Rx - diversityrx.org
- The Border Consortium, Burma - theborderconsortium.org

Refugee Health Elective Commentary: Lindsey Lane BM BCh

This description of the Refugee Health II Elective drives home the point that a curriculum is not just a list of topics and readings.

Instead, it is a carefully planned educational experience that focuses on learning of previously defined knowledge, attitudes and skills. Knowledge quizzes, retrospective pre and post course self-assessments, reflective writing and direct observation of skills are the methods this curriculum uses to evaluate the students who participate in the elective. Using these methods assures us that participants have learned what we wanted them to learn.

Students also evaluate each component of the curriculum and the overall elective. All of the evaluation data is used to make ongoing improvements in the learning experience.

Previous newsletters have discussed curriculum development, assessment and evaluation and the importance of communication in healthcare – it’s time to take a look at the educational experiences we’re responsible for and make sure that we’re ‘doing it right’!

Citations: AMA style

iv. Website for the ACGME Outcomes Project Staff. Created April 23, 2002. Available at: https://dconnect.acgme.org/outcome/project/glossary2.asp