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Human Trafficking in the Emergency Department

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Human trafficking continues to persist, affecting up to 200 million people worldwide. As clinicians in emergency departments commonly encounter victims of intimate partner violence, some of these encounters will be with trafficking victims. These encounters provide a rare opportunity for healthcare providers to intervene and help. This case report of a human trafficking patient from a teaching hospital illustrates the complexity in identifying these victims. Clinicians can better identify potential trafficking cases by increasing their awareness of this phenomenon, using qualified interpreters, isolating potential victims by providing privacy and using simple clear reassuring statements ensuring security. A multidisciplinary approach can then be mobilized to help these patients. [West J Emerg Med. 2010;11(5); 402-404.]

INTRODUCTION

Human trafficking is usually discussed in the framework of human rights rather than health. However, engaging healthcare workers in preventing continued trafficking and caring for victims remains a challenge, despite the fact that these practitioners are in an ideal position to intervene. Healthcare providers, particularly emergency department (ED) personnel who often care for the disenfranchised are far more likely than the general population to interact with trafficking victims. Furthermore, these providers have a long history of identifying and assisting victims of intimate partner violence. Just as recognizing victims of intimate partner violence has become an integral part of every patient assessment in EDs, hospitals and physician's offices, healthcare providers should learn how to identify trafficking cases.

The United Nations currently defines trafficking as:

“The recruitment, transportation, transfer, harboring and 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 a position of vulnerability or of the giving or receiving of payment or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at minimum the exploitation of

*the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs.”*¹

Trafficking of human beings is one of the most profitable businesses in the world today with annual revenues estimated at \$9.5 billion.² At least 27 million and perhaps as many as 200 million people are estimated to be enslaved on our planet in 2008.² Slavery and trafficking has been documented in nearly every country, and current estimates place the number of persons annually trafficked across borders at 700,000 to 900,000 worldwide. The United States (U.S.) State Department asserts that at least 20,000 people are trafficked into the U.S. each year: 75% of the victims are in the commercial sex industry while 7% are in bonded labor. The remaining 18% of victims trafficked into the U.S. are forced into a variety of other forms of enslavement.³

Identifying trafficking victims is extraordinarily difficult. U.S. hospital EDs do not have databases of presenting complaints for this population. Victims of human trafficking have no “classic” presentation and often suffer from a variety of physical and mental health conditions.^{4,5,6} In international trafficking cases, language barriers and victims' fear of authority (including healthcare workers) complicate an already

difficult task. Victims may be unfamiliar with Western or developed nations' healthcare systems.

Nonetheless, with appropriate training and awareness, healthcare providers can learn to identify and help trafficking victims. We present below a case example of a patient that presented to the Massachusetts General Hospital (MGH) ED, a facility affiliated with Harvard Medical School, with an annual volume of about ninety-thousand patients.

CASE REPORT

A 36-year-old Spanish-speaking female was transported by police to the MGH ED for "intimate partner violence." The initial history was vague on details: She reported that she had been living with her "boyfriend" for the previous two months, but in recent weeks was told she "constantly made mistakes" and was "punished for them" by the perpetrator. Her vital signs were normal. Examination revealed several ecchymoses in various stages of healing about her eyes and ears, her left shoulder, and her upper left thigh. There was no evidence of fractures.

Through a medical interpreter, a more detailed history revealed that her plight had been more complicated than was initially reported. Several months prior, she had been living in her home in Colombia, and was "befriended" by a woman who claimed that she was visiting the country temporarily. This new "friend" electronically introduced her to a man living in Massachusetts. After a brief period of email exchanges, our patient traveled to Massachusetts to meet her new online romance. She claimed to have been swept off her feet, and noted that "everything seemed perfect." However, within days, she found herself trapped and feeling helpless. He took away her passport and forbid her to leave his home. The romance was quickly replaced by endless work with physical and sexual abuse. After a few weeks, the woman that our patient had met in Colombia arrived at the home and took her place as the man's true spouse. On the day that our patient was transported to MGH, she had escaped the home and run to a neighbor for help.

DISCUSSION

This case provides several clues that this patient was a human trafficking victim. First of all, the patient did not initially reveal her true situation, revealing more details once a medical interpreter was employed. The reluctance of victims to disclose their true situations is well described in the literature.⁷ There may be several reasons for patients' fears: (1) they view authority figures as being complicit in their victimization; (2) they are afraid that their abusers may find out about their revelations and punish them; and (3) they believe they will bring shame to their families or communities back home.⁷

Second, on initial examination, the patient noted "making mistakes" and "being punished" as a consequence. Many international trafficking victims may not speak English, and

these subtleties in the history may only be picked up with the help of a qualified medical interpreter. Studies show that using a translator in clinical histories more often reveals important clinical information than histories taken in their absence.⁷ Additionally, further studies report that patients who are not proficient in English leave health facilities with a greater understanding of the information imparted to them by providers as well as higher satisfaction when interpreters are used.⁹

Third, the victim came to the ED by herself. By coming alone, she had the opportunity to disclose to healthcare practitioners what was happening to her. In many cases of trafficking, the perpetrators will accompany victims to the health facility posing as a friend or family member. The trafficker may offer to translate for the victim, speak on behalf of the victim, and/or insist on remaining in the examination room. While the presence of a "friend" or "family member" may seem fortuitous to healthcare practitioners in a busy ED, given the delays in patient flow due to finding an interpreter, the results could be very harmful for the victim. The literature on intimate partner violence suggests that providing victims with privacy may lead to more complete disclosures than those taken with family or friends present.^{10, 11}

As evidenced by this case report, the identification of trafficking victims is never easy, because victims may present with vague chief complaints or only psychiatric symptoms. However, the case report suggests that healthcare practitioners can increase their likelihood of identifying trafficking victims by: acknowledging victims' fears and providing a secure, non-judgmental environment in which to tell their stories; isolate suspected trafficking victims from anyone accompanying them to health facilities; and insist on using qualified interpreters when obtaining patient histories. Once a victim has been identified, healthcare practitioners should activate a multi-pronged, team response. Social workers and case managers should be engaged immediately to identify resources for victims (e.g., housing, food, medical care, legal services), and local law enforcement should be notified.¹²

SUMMARY

Human trafficking is flourishing in the world today and poses serious health risks for victims. Healthcare practitioners, particularly emergency physicians and other ED health workers, are well-positioned to identify and assist victims. However, as exemplified by our 36-year-old patient, practitioners must be sensitive to the widespread presence of trafficking and understand victims' vulnerabilities and critical needs. More resources should be devoted to training healthcare practitioners about this emerging issue and equipping healthcare systems to address the trafficking issue head-on.

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