

Simulation-Based Trauma-Informed Care Education Instills Empathy and Improves Clinician Practices Towards Refugee and Migrant Populations

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Abstract

Introduction: Refugee and migrant communities carry histories wrought with trauma. These traumas and trauma-related responses often contribute to feelings of mistrust towards Western health care systems and can additionally foster negative clinician biases (conscious or unconscious) and attitudes towards these communities. Consequently, clinicians often fail to uncover underlying causes of poor health and distress for their refugee and migrant patients. **Methods:** To dismantle biases and cultivate empathy towards refugee and migrant patients, we developed a 1-hour simulation-based educational workshop to train clinicians to think critically about incorporating trauma-informed care (TIC) for these patients' unique needs. We introduced this tool to the GME curricula at Texas Tech University ($n = 36$) and to the UME curricula at Albany Medical College ($n = 43$). Using pre- and postquestionnaires, we analyzed the impact of this workshop on participants' knowledge, attitudes, and practices regarding TIC for migrant and refugee populations ($n = 44$). **Results:** This tool positively influenced students' and residents' knowledge and attitudes regarding TIC and displaced peoples, and learners expressed greater willingness to incorporate TIC into clinical practice ($p < .001$). Additionally, residents self-reported percentage increases in behaviors that promote equitable care for refugee and migrant patients 6 months postintervention. **Discussion:** This training enhanced clinicians' trauma-informed practices towards refugee and migrant patients, with learners qualitatively expressing a greater sense of empathy towards this community. While measuring the impact on learners' empathy requires further assessment, this educational innovation's preliminary success provides a foundation for the role of simulation-based learning in medical education.

Keywords

Trauma-Informed Care, Refugee Health, Migrant Health, Diversity, Equity, Inclusion, Cultural Competence, Health Equity, Health Literacy, Case-Based Learning, Simulation, Standardized Patient

Educational Objectives

By the end of this activity, learners will be able to:

1. Identify misconceptions about displaced peoples' origins.
2. Highlight the contributions of refugees and migrants to our society.
3. Outline barriers to health care access that refugee and migrant communities face.
4. Define aspects of the Western health care system that may retraumatize refugee and migrant patients.
5. Illustrate how clinicians can address displaced peoples' barriers to health care and resist retraumatization.

6. Practice empathy towards refugee and migrant patients while navigating health care systems.

Introduction

Of the 117.3 million forcibly displaced people worldwide,¹ over 200,000 refugees and migrants cross into the U.S. each month,² many of whom settle in various cities across the country. In the U.S., one in four children have an immigrant parent, and more than one in 10 children are U.S. citizens with a noncitizen parent.³ Additionally, one in 30 people in the U.S. live without documentation.⁴ As the numbers of refugees and migrants are only expected to increase due to current economic, political, and social upheaval,⁵ clinicians across the nation are guaranteed to care for patients in this population. Therefore, to ensure these patients receive equitable, holistic, high-quality care, it is imperative that trauma-informed care (TIC) and empathy-building exercises are integrated into medical education.

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Despite the U.S.'s growing presence of refugees (individuals who have faced direct persecution in their home countries due to their race, religion, nationality, political opinion, or social group)¹ and migrants (individuals who have fled their home countries due to economic or indirect social violence),¹ these populations continue to receive inequitable health care, due in part to physician biases and lack of cultural humility.⁶ Furthermore, migrant and refugee communities are overwhelmingly dehumanized, often reduced to numbers and statistics. Yet, behind every number is a face, a family, a story.

Dehumanization of the refugee and migrant population is pervasive, occurring in every aspect of health care as clinicians often misinterpret difficulties with access to care as avoidance of medical treatment or disinterest in one's own health. Clinicians often inadvertently place blame for poor health management onto already oppressed patient populations rather than considering the effects of structural injustice in health care access. Migrants and refugees are often criticized for not speaking English, and many are denied interpreters during medical care.⁷ Additionally, immigrant patients possess a wide array of legal statuses,⁴ sometimes fearing deportation in medical settings.⁸⁻¹⁰ Frequently, migrant patients' wishes regarding the presence of family, the use of non-Western healing practices, and personal modesty are disregarded as well. This neglect leaves patients confused and disoriented, further estranging them from Western health care.¹¹ Furthermore, health care professionals often fail to adequately explain discharge and follow-up procedures to immigrant patients, who tend to have low health literacy and limited education levels, making it difficult to effectively manage their own care.⁷ The American health care system is costly, disjointed, and difficult to navigate, especially for patients already experiencing high levels of trauma, posttraumatic stress disorder, mistrust, and heightened barriers to care.¹² Therefore, health care settings frequently retraumatize refugees and migrants, often deterring them from seeking care before experiencing life-emergent health crises.¹³

To combat the biases of health care professionals and reestablish trust between refugee and migrant communities and the Western health care system, medical education must incorporate TIC and empathy-based training. TIC focuses on shifting the narrative from "What is wrong with you?" to "What has happened to you?"¹³ This reframing encourages clinicians to examine unique barriers patients face when accessing health care and engage in collaborative solutions to address them.¹³ TIC invites patients into a safe environment intentionally created by the health care team

that welcomes patients to share aspects of their life that impact their health and may otherwise be overlooked. As refugees and migrants frequently experience a lack of situational control, poor relationships with authority figures, and unsafe environments, approaching these patients with TIC can aid in personal recovery and mend tumultuous relationships with health care. Using TIC, health care professionals work to earn patient trust by making collaborative, informed decisions, and emphasize patients' resilience through adversity.

While medical educators often recognize how social determinants of health disproportionately affect migrant and refugee populations,^{14,15} existing educational approaches focus on clinician-patient encounters rather than asking clinicians to place themselves directly in their patients' shoes.¹⁶⁻¹⁸ These approaches leave risk for othering patient populations, while empathy-building exercises form firsthand experiences that change clinical practice.^{19,20} To combat this gap in curriculum, our educational innovation uses first-person case-based learning to encourage clinicians to consider the decisions someone experiencing forced-displacement might endure.

Paired with an overview of TIC and general education surrounding refugees, asylum seekers, migrants, and the journey of a displaced person, our case-based simulation tool challenges clinicians to empathize with their patients in a truly unique way. As clinicians work through each case, they evaluate barriers to health care that they may not have previously considered and use that knowledge to approach future patients with a greater sense of compassion and empathy. When health care professionals place themselves in their patients' shoes, they are more likely to feel *with* them, leading to improved care and better patient outcomes.²¹

Methods

Journey Tool Development

We illustrated the journeys of displaced peoples as three different first-person cases that place clinicians in scenarios that refugee and migrant populations may encounter (Appendix A). To generate these scenarios, we combined representative stories of individuals encountered through both authors' professional interactions and published articles. We deidentified all stories to protect individuals' identities while painting a broad and inclusive picture of their experiences. Using these narratives, we created an interactive first-person simulation tool that walks participants through specific choices that refugees and migrants may be forced to contemplate while seeking safety in the U.S. (Appendix A, Case 1), while in detention (Appendix A, Case 2), and while experiencing labor-intensive jobs (Appendix A, Case 3).

Educational Innovation

To increase knowledge and foster empathy, we integrated the tool into an accompanying training that humanizes the experiences, obstacles, and traumas that refugee and migrant communities face when accessing health care. Our training began with a 40-minute background presentation on TIC, refugee and migrant demographics on a global and local level, the journeys displaced people may endure, and key action items clinicians can employ to empower their patients (Appendix B). Then, we divided learners into groups of five to eight participants and assigned one interactive case scenario to each group (Appendix A), allowing them 15 minutes after the initial presentation to work through their respective cases. Lastly, we brought all learners together for a 5-minute large-group discussion surrounding the impact of these exercises on their understanding of the unique barriers that refugees and migrants may experience with a focus on how TIC can be used to overcome these challenges (Appendix C).

Implementation and Evaluation

We delivered this educational innovation to emergency medicine residents, family medicine residents, and fourth-year medical students at Texas Tech University Medical Center in El Paso, Texas as part of their programs' required didactics. Additionally, we offered this training as an optional session for interested first-, second-, and third-year medical students at Albany Medical College in Albany, New York as part of professional development curricula.

We administered the workshop to eight groups of learners ($N = 100$) at two academic medical centers, who were given the opportunity to participate in a presurvey and postsurvey (Appendix D). The 30-item questionnaire utilized a 5-point Likert scale designed to assess the impact of the workshop on participants' knowledge, attitudes, and practices regarding TIC and the refugee and migrant population.

We utilized 13 items (Appendix D: Q1, Q2, Q11, Q12, Q13, Q19, Q20, Q24, Q25, Q26, Q27, Q28, Q30) from a validated tool to assess TIC educational innovations,²² and we generated the 17 remaining items for the survey. Newly developed questions were brainstormed using both our own implicit biases towards refugees and migrants, as well as common misconceptions we encountered amongst our peers.

Using Qualtrics, an online survey platform, we collected nonidentifiable information to pair pre- and postsurvey responses for analysis. To evaluate the impact of the workshop on the long-

term clinical implementation of TIC, the practices subsection of the postsurvey was redistributed to all resident participants 6 months after the initial workshop.

Postworkshop Feedback

To identify the workshop's strengths and areas for improvement, we analyzed notes taken during debrief discussions immediately following the training for consistent themes. Notes were recorded by observing faculty with no involvement in curriculum development or data analysis and consisted of all verbal comments made during the discussion. Recommendations for the training included involving standardized patient (SP) cases, which were developed and implemented for family medicine residents at Texas Tech University Medical Center in El Paso, Texas following the initial training.

Data Analysis

Using survey data collected on a 5-point Likert scale, we conducted the Mann-Whitney U test to assess differences in pre- and postworkshop responses to knowledge and attitude-based questions.²³ We further investigated significant associations for these questions using linear regression analysis, stratifying by level of medical training. Our data analysis excluded participants who did not complete both the pre- and postworkshop survey. We defined p values $< .05$ as significant and performed statistical analyses using RStudio, version 1.2.5033 (RStudio Team).

Additionally, to assess the workshop's effectiveness in increasing self-implementation of TIC practices, we calculated the percentage increase between pre- and 6-month postworkshop responses from resident physicians. We excluded medical students from this analysis, as the assessed practice-based questions were not as applicable to this demographic.

Lastly, we analyzed qualitative data taken from verbal reflections noted during debrief discussions for consistent responses to the educational innovation.

Replicability

To ensure reproducibility of our workshop and currency of the data, we developed a facilitator guide (Appendix E) and statistical graphic (Appendix F) that will allow future workshop administrators to host the educational exercise effectively and tailor materials to their learners and present time.

Ethical Approval

The Albany Medical College and Texas Tech University Health Sciences Center Institutional Review Boards deemed further review of this project not necessary.

Results

Learners

A total of 45 emergency medicine residents, family medicine residents, and fourth-year medical students at Texas Tech University Medical Center in El Paso, Texas participated in the workshop, of which 36 completed the presurvey and 21 completed the postsurvey. Similarly, 55 first-, second-, and third-year medical students at Albany Medical College in Albany, New York participated in the optional workshop, of which 43 completed the presurvey and 23 completed the postsurvey. Our response rate across all levels of training and both institutions was 44%. Participants were spread across eight different sessions that were offered during didactic portions of the respective institutions' curricula.

Knowledge and Attitudes

To gauge the evolution of participant responses ($n = 44$), we utilized a pre- and postworkshop survey designed to encompass core concepts outlined in the educational objectives and delve into their knowledge, attitudes, and practices concerning the refugee and migrant populations. Participants displayed a statistically significant increase in knowledge regarding the presence of refugees and migrants within their social and health care spheres ($p = .02$; Table 1), the level of protection offered between immigrants, migrants, and refugees ($p = .02$; Table 1), and the holding of asylum seekers in detention centers ($p = .02$; Table 1). Significance remained after stratification by level of medical training for both medical students and residents in knowledge regarding the presence of refugees and migrants within their social and health care spheres ($p < .001$; Figure 1A). When assessing the association of pre- and postsurvey data by level of medical training for knowledge regarding the level of protection offered between immigrants, migrants, and refugees, and the holding of asylum seekers in detention centers, statistical significance was observed for the medical student group only ($p = .006$, $p = .02$; Figure 1B and

1C). Moreover, we observed a statistically significant increase in knowledge regarding the decision to come to the U.S. ($p = .006$; Table 1) and in attitudes regarding a comprehensive understanding of and willingness to incorporate TIC ($p < .001$; Table 2). Questions related to taxation of undocumented individuals, eligibility for asylum, the use of interpreters, the use of cultural healing practices in Western medicine, working with non-English-speaking patients, the influence of one's actions as a clinician, and the use of TIC in effective collaboration with patients and families showed no significant difference between pre- and postsurvey responses (Tables 1 and 2).

Practices

Considering the spectrum of our participants' level of training, we only included practice-based responses from resident physicians to measure the impact of the workshop on clinical practice. Compared to their preworkshop survey, 6-months postworkshop, participants demonstrated a 13% increase in proper use of an interpreter, a 17% increase in obtaining patient permission before approaching sensitive topics and physical exam maneuvers, a 16% increase in collaboration with local organizations, and a 17% increase in maintaining an open space to discuss past traumatic experiences (Table 3). Additionally, participants displayed a 19% increase in advocating for their patients to change local, statewide, or national policies (Table 3).

Impact

Overall, several participants offered positive verbal feedback immediately after the educational innovation. During debrief discussions, several learners highlighted how the TIC presentation and first-person cases made them feel "stressed," "anxious," and "on the edge of their seats." Many expressed the exercise allowed them to form a stronger sense of empathy for their refugee and migrant patients as they attempted to "place [themselves] in the shoes of the person's case" and battled against "no good options."

Table 1. Mean Difference in Knowledge Scores Among All Participants ($N = 44$)

Item ^a	Baseline Score <i>M (SD)</i>	Postworkshop <i>M (SD)</i>	<i>p</i>
Refugees and migrants are my fellow students, colleagues, and health care professionals.	4.6 (0.8)	4.8 (0.7)	.02 ^b
All refugees and migrants come to the United States voluntarily.	2.1 (1.1)	1.7 (1.1)	.006 ^b
Immigrants, migrants, and refugees are given the same protections under United States policy.	1.8 (1.1)	1.5 (1.0)	.02 ^b
People without documentation pay more in premiums and taxes than insurers and government pay for their health care.	3.4 (1.4)	3.8 (1.6)	.06
People who have experienced gang violence abroad are eligible to seek asylum.	3.6 (1.1)	2.9 (1.6)	.05
People seeking asylum can be held in detention centers indefinitely once in the United States.	3.5 (1.4)	4.2 (1.0)	.02 ^b

^aRated on a 5-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*).

^bSignificant at $p < .05$.

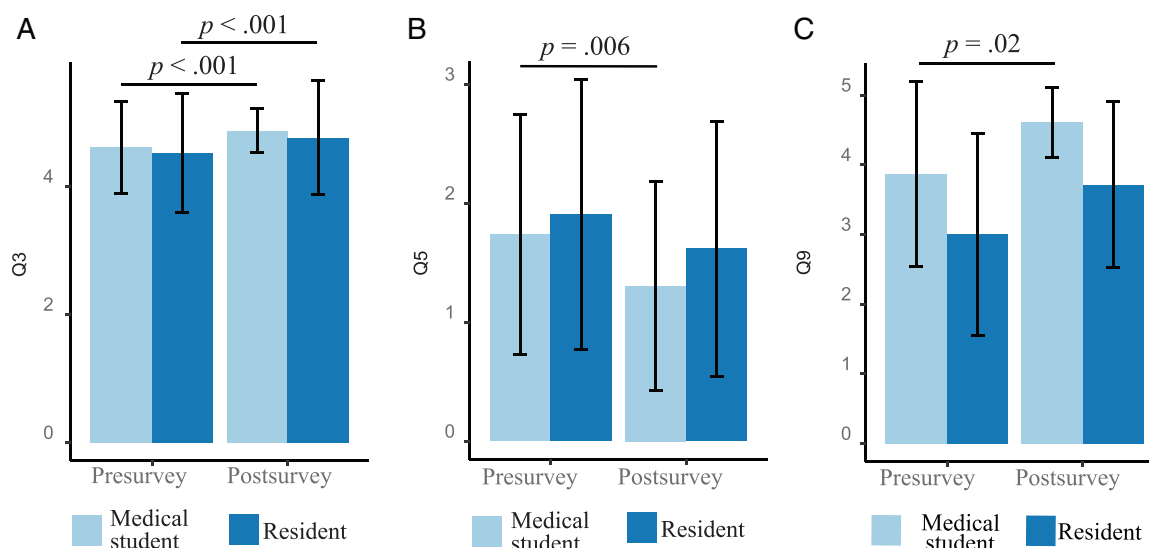


Figure. Distribution of mean pre- and postworkshop responses ($N = 44$) by medical student (light blue) and resident (dark blue) level of training in response to statements: (A) Refugees and migrants are my fellow students, colleagues, and health care professionals; (B) Immigrants, migrants, and refugees are given the same protections under United States policy; and (C) People seeking asylum can be held in detention centers indefinitely once in the United States. Relationships were assessed using linear regression models with stratification by level of medical training.

Discussion

Throughout development of this educational innovation, our goal was to uplift the voices of refugees and migrants who we accompanied as they navigated accessing health care in the U.S.^{24,25} Throughout this process, we reflected on the many decisions that displaced people face, grappling with how traumatic circumstances can both influence one's holistic health (physical and psychological) and their willingness to seek health care.

Naturally, these reflections inspired us to integrate these narratives with TIC strategies to think critically about providing equitable care. The TIC approach allowed us not only to honor the stories of refugee and migrant patients, but also gave us a platform with which we could welcome self-reflection.^{13,26} Thus, we tailored the presentation portion of the TIC training

to empower learners to take away specific lessons about the histories of refugee and migrant communities.

To combat biases towards refugee and migrant populations, we wanted learners to understand how mainstream media and our legal system often criminalize those seeking refuge, creating dangerous perceptions that can negatively impact clinician-patient relationships.^{27,28} Migrants at the U.S.-Mexico border, for example, often make the treacherous journey out of necessity for their own safety and livelihood. However, many sociopolitical leaders dehumanize those in need of safety and enforce a legal system that often undermines our nation's lauded values of liberty, justice, and equity.

Furthermore, we wanted learners to understand that common assumptions of patient health literacy may be false when working with vulnerable populations. For example, patients new to

Table 2. Mean Difference in Attitudes Scores Among All Participants ($N = 44$)

Item ^a	Baseline Score M (SD)	Postworkshop M (SD)	p
Any family member is qualified to serve as a medical interpreter for patients with limited English proficiency.	2.1 (1.3)	2.3 (1.5)	.71
The practices of Western medicine supersede cultural healing practices when it comes to my patients' care.	2.2 (1.3)	2.0 (1.2)	.59
When working with non-English-speaking patients, there is no harm in making negative remarks in English if patients do not understand you.	1.2 (0.8)	1.2 (0.9)	.72
My actions as a physician can influence the relationship with a community of people and Western medicine.	4.9 (0.3)	4.9 (0.3)	.51
Trauma-informed care is essential for working effectively with patients and their families.	4.8 (0.4)	5.0 (0.2)	.10
I have a comprehensive understanding of and will continue to incorporate the practice of trauma-informed care.	3.7 (1.1)	4.7 (0.5)	<.001 ^b

^aRated on a 5-point Likert scale (1 = *strongly disagree*, 5 = *strongly agree*).

^bSignificant at $p < .05$.

Table 3. Percentage Increase in Practices Among Residents Immediately Postworkshop

Item ^a	Baseline Score M (N = 35)	Postworkshop M (N = 21)	6-Month Postworkshop M (N = 11)	% Increase ^b
When using an interpreter, I speak directly to the patient.	4.3	4.5	4.9	13
I ask patients for permission before approaching sensitive topics and performing physical exam maneuvers.	4.3	4.4	5.0	17
I maintain an open space for conversations regarding past trauma and/or ACEs for all my patients.	4.0	4.0	4.7	17
I collaborate with local organizations to ensure that my patients can fulfill needs that contribute to their well-being (e.g., food pantries, legal agencies, shelters for the unhoused).	3.3	3.2	3.8	16
I advocate for my patients through attempting to change local, statewide, or national policies.	2.6	2.4	3.1	19

Abbreviation: ACE, adverse childhood experience.

^aRated on a 5-point frequency scale (1 = *never*, 5 = *always*).

^bPercentage increase in mean baseline score and 6-month follow-up score.

the U.S. may not know the difference between primary care and emergency care settings or understand that outpatient medication is dispensed at a separate pharmacy. Those in asylum proceedings may be wary of medications that require proof of identity during purchase. People living in shelters may not have control over the foods they eat, the hours they work, or the frequency with which they use the bathroom. As health care professionals, empathizing with these circumstances empowers us to think critically to develop creative, collaborative solutions that make treatment plans more accessible.

Lastly, we wanted learners to understand that everyone brings unique perspectives, experiences, and stories when they walk into a health care setting.²⁵ The moments we share with patients in medical settings are mere fragments of what they have experienced before arriving to us, and what they will experience after they leave. Therefore, we must approach every encounter with humility, kindness, an open heart, and an open mind.

To ensure our curriculum continues to emphasize these ideals, we created a guide to help prepare future workshop facilitators in leading learners towards these lessons (Appendices E-F). Though future workshop-facilitators may not have formal training in TIC, we hope their diverse perspectives enhance our curriculum given the prepared materials to aid in replicability.

Our educational innovation was designed to reach an attentive audience within the time constraints of existing undergraduate and graduate medical curricula. As such, the workshop was designed to last 1 hour from beginning to end. This concise structure proved valuable when advocating for the incorporation of this workshop into the existing didactic framework.

However, we believe our educational model should be better integrated as a theme throughout medical didactic curricula.

Continuous learning and reflection would lead to richer, more thought-provoking discussions amongst learners and better care for patients.²⁹ First-person simulation-based cases can be integrated as stand-alone small-group workshops in the weeks to months following an initial introduction to TIC. This format would provide learners ample time to develop their TIC skills and better integrate these practices into patient care longitudinally.

Overall, evaluation of the educational innovation via the validated questionnaire²² showed that the workshop changed the knowledge and attitudes of learners. Additionally, learners valued the educational innovation and expressed a need for further education regarding TIC approaches for vulnerable populations.

The results of our evaluation are limited by a small sample size of learners ($n = 44$), many of whom are already actively engaged with the refugee and migrant community. Because our training was delivered to resident learners completing their training at the U.S.-Mexico border and to students with a special interest in this topic, certain biases may be more prevalent amongst the larger health care community. Therefore, the impact of our educational innovation on such biases may not have been fully evaluated. To reach a wider, more diverse audience, we intend to integrate this model into the mandatory didactic curriculum at our medical institution.

Furthermore, our evaluation does not adequately measure the improvement of learners' TIC practices, as a further limited number of participants ($n = 11$) filled out the postsurvey 6 months after the initial workshop. Therefore, the number of responses may be insufficient to assess the impact of the educational innovation on learners' self-implementation of TIC practices. To better assess how the workshop impacts clinical practice

long-term, we seek to deliver this educational innovation to wider physician audiences.

Lastly, the impact of our simulation-based tool on learners' empathy was only qualitatively assessed, with participants verbally expressing a greater attention to patients' personal experiences as the simulation-based exercise allowed them to "stand in [patients'] shoes." Though these statements are reflected in formal assessments of empathy in medical education,³⁰ we hope to further assess the educational tool's impact on participants' empathy using validated empathy scales.³⁰

Workshop participants expressed a desire for simulation and case-based learning within medical education at large. In fact, family medicine resident participants advocated for further training in this area to their faculty members, who subsequently invited us to generate SP case files for a soft skills session, allowing residents a safe space in which to practice implementing TIC. These SP cases will be disseminated pending further development and testing.

As it stands, our educational workshop includes cases that focus on migrant journeys. However, refugee and migrant populations are incredibly heterogeneous, consisting of people with a wide variety of experiences and trauma. Our workshop would benefit from simulation-based cases examining the experiences of refugees and nonmigrant immigrants to broaden the scope of what our educational tool can offer.

We believe that the structure of our TIC training and the use of a first-person decision-making exercise to effectively build clinician empathy can be applied to several different vulnerable populations in health care. In collaboration with clinicians who are passionate about working with marginalized groups in medicine, including but not limited to the Black community, the LGBTQ+ community, the incarcerated community, minoritized faith communities, and communities experiencing weight bias, we hope to utilize this platform to frame ongoing discussions surrounding TIC approaches and empathy in every patient encounter.

Appendices

- A. TIC Cases folder
- B. TIC Approaches for Refugees & Migrants.pptx
- C. Discussion Questions.docx
- D. Session Evaluation.docx

E. Facilitator Guide.docx

F. Refugee Statistics Editable Chart.xlsx

All appendices are peer reviewed as integral parts of the Original Publication.

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Prior Presentations

Audil A, Martinez A, Palnati M, Tovar E. Utilizing trauma informed care principles to enhance care for refugee and migrant populations.

Presented virtually at: Trauma Informed Health Care Education & Research (TIHCER) National Meeting; April 29, 2024.

Audil A, Martinez A, Palnati M, Tovar E. Utilizing trauma informed care principles to enhance care for the refugee and migrant population. Presented at: Gold Humanism Healthcare Summit; February 28-March 2, 2024; Atlanta, GA.

Audil A, Martinez A, Palnati M, Tovar E. Trauma informed care approaches to refugee and migrant healthcare. Presented at: Albany Medical College Community Grand Rounds; April 19, 2023; Albany, NY.

Palnati M, Audil A, Martinez A, et al. Addressing social determinants of health and healthcare access for the refugee & migrant population through trauma informed care at the Juarez/El Paso border. Poster presented at: Albany Medical College Medical Student Investigation Day; October 4, 2023; Albany, NY.

Ethical Approval

The Albany Medical College and Texas Tech University Health Sciences Center Institutional Review Boards deemed further review of this project not necessary.

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