Teaching Residents to Work with Torture Survivors: Experiences from the Bronx Human Rights Clinic

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INTRODUCTION: Despite the 1984 United Nations's Convention Against Torture calling to train doctors to work with torture survivors, many physicians are unaware of their obligation and few are taught the requisite clinical skills.

AIM: To describe the development, implementation, and evaluation of a curriculum to teach residents to work with torture survivors.

PARTICIPANTS: Medicine residents in New York City

PROGRAM DESCRIPTION: A 2-component curriculum consisting of a series of workshops and clinical experiences, which provide content, skills, and practices regarding the medical, psychological, ethical, and legal aspects of evaluating and caring for torture survivors.

CURRICULUM EVALUATION: All 22 trainees received surveys before and after training. Surveys assessed residents' relevant prior experience, beliefs, skills, and attitudes regarding working with torture survivors. At baseline, 23% of residents described previous human rights trainings and 17% had work experiences with torture survivors. Before the curriculum, 81% of residents reported doctors should know how to evaluate survivors, although only 5% routinely screened patients for torture. After the curriculum, residents reported significant improvements in 3 educational domains—general knowledge, sequelae, and self-efficacy to evaluate torture survivors.

DISCUSSION: This curriculum addresses the disparity between doctors' obligations, and training to work with torture survivors. It is likely to achieve its educational goals, and can potentially be adapted to other residencies.

KEY WORDS: torture; survivors; doctors; New York City; resident education.
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INTRODUCTION

Doctors have a professional obligation to evaluate and treat torture survivors. The Universal Declaration of Human Rights, adopted by the United Nations in 1948, established that doctors are duty-bound to support human rights and basic humanitarian laws.[1] The 1984 United Nations Convention Against Torture called to educate all doctors to identify and treat survivors.[2] These declarations have been ratified by the United States government and the American College of Physicians, among others. However, few medical schools train their learners to work with torture survivors.[3–5]

In the United States, there are over 500,000 foreign-born torture survivors, and about 20 percent of these live in New York City's metropolitan area.[3] Torture, in the human right context, is defined as acts that cause intense physical or psychological pain, are volitional, are done to punish or coerce, and are sanctioned actively or passively by governments or their agents. Although 5–11% of foreign-born patients at US urban medical centers are torture survivors, doctors often are unaware of this medically relevant information.[4–7] In 2000, Eisenman found a 7% torture history prevalence among a New York City public hospital's primary care clinic. None were identified as survivors by their doctors.

The Bronx Human Rights Clinic (BHRC) was established to address the disparity between doctors' obligations and awareness of torture. BHRC, located at the Community Healthcare Center (CHCC) in New York City, is in the clinical home for Montefiore Medical Center's Primary Care and Social Medicine (PC/SM) residency programs. The PC/SM programs are committed to producing, in an environment of academic rigor and innovation, clinicians and physician-leaders equipped to improve the health of society, particularly that of underserved populations. This article is the first to describe the development and implementation of a curriculum to teach medical residents clinical skills to evaluate torture survivors.

CURRICULUM DEVELOPMENT

The BHRC was established in 1993 as a collaboration between Montefiore's PC/SM residency programs and the humanitarian program Doctors of the World (DOW).[8] DOW provides services for communities endangered by violations of human rights and civil liberties and trains providers to sustain these

missions. The goal of our curriculum is to prepare residents to actively contribute to social justice by advocating for torture survivors. The specific objectives of BHRC are: to train residents to medically and psychologically evaluate survivors, write affidavits for asylum proceedings, and link applicants to medical, mental health, and social services.

The BHRC curriculum has 2 components—a training curriculum and clinic curriculum. Lacking training models specific to residents, we used DOW's full-day training program for new volunteers as a template. We modified its length and content to be appropriate for residents, and streamlined DOW's psychiatric and gynecological modules. We distributed surveys to assess residents' needs and experiences regarding this curriculum. Using this acquired knowledge, we built an experiential clinic curriculum.

CURRICULUM DESCRIPTION

Training Curriculum

Implemented in 2002, this mandatory required curriculum is a series of 8 workshops delivered in one 4-hour block, to all house officers en masse, during Postgraduate year (PGY) 1. Topics include identifying doctors' ethical obligation to work with survivors, explaining basic legal aspects of asylum, and teaching about torture's medical and psychological sequelae. Workshops include case presentations of applicants seen in BHRC, didactic and small group discussions led by experts in law, medicine, and mental health (Table 1). Training materials include DOW's training manual, sample affidavits, and a court preparation guide (available upon request).

Clinic Curriculum

Residents start in BHRC as PGY 2s, 1–3 months after they received the training curriculum. This longitudinal experience during the second and third years of residency reinforces the training curriculum, and provides hands-on practice working with torture survivors.

Residents participate in 1 BHRC session monthly, evaluating 1 applicant per session, during all of their 9 PGY 2 and 3 residency ambulatory months. Applicants are referred to BHRC subsequent to intake at DOW. Resident–preceptor pairs meet during the BHRC session before commencing evaluations to review applicant packets (including their narrative statement and social-political profiles from Human Rights Watch), review the training curriculum, and develop specific evaluation and affidavit-writing strategies regarding assigned clients. Establishing resident–preceptor pairs before sessions facilitates this process. Thereafter, applicants are evaluated.

Evaluations take roughly 3 hours and are conducted in half-day sessions. As taught in the training curriculum, residents

Table 1. Training Curriculum Workshops

Workshop Title	Objectives	Facilitators' Training*	Methods
A History of Torture	To define torture and its prevalence	Two General Internists	Interactive discussion
	To provide a sociopolitical and historical context		
	To explain international codes of conduct regarding use and prevention of torture		
Asylum Law	To explain basic United States asylum law	Immigration lawyer	Interactive discussion
	To present the challenges facing asylum seekers navigating the United States' legal system		Case presentation
Medical Sequelae	To describe the 6 most common types physical maltreatment—blunt trauma, burns, suffocation, sharp objects, electrical torture, genital/sexual torture	A General Internist and A Gynecologist	Interactive discussion
	To explain acute and long-term sequelae		Case presentation
			Photograph review
Psychological Sequelae	To describe the psychological impact of torture	Clinical psychologist or Psychiatrist	Interactive discussion
	To describe the most common diagnoses		
	To review criteria for posttraumatic stress disorder		
Approach to Evaluation	To explore the purpose of an evaluation	General Internist	Interactive discussion
	To explain how to minimize retraumitization		Case presentation
	To review effective use of translators		
Who do we see at BHRC?	To describe demographics, types of torture and sequelae of survivors seen in the clinic	General Internist	Interactive discussion
Effective affidavit writing	To describe how to write a useful affidavit	Immigration Lawyer and General Internist	Interactive discussion
	To explain how to prepare to testify in court		Affidavit review
What is it like to work here?	To present residents' perspective of their experience	General Internal Medicine Chief Resident	Resident testimonials
	To explore secondary trauma and provider self-care		Interactive discussion

All facilitators are experienced working with torture survivors

use a standardized clinical evaluation format derived from the "Manual of Degrading Treatment or Punishment".[9] If applicants are not fluent in English, communication is through translators provided by their lawyers, or via telephone translation with dual-headset phones.

BHRC has 4 faculty preceptors. Their professional expertise is global health and human rights. Residents present their evaluations as case conferences and are precepted together within a closed conference room. Subsequently, and with the applicants' permission, resident–preceptor pairs lead small groups of resident-doctors to see each applicant. These small groups review and refine evaluations. Resident–preceptor pairs then directly offer applicants referrals to return for medical care at CHCC with their evaluating doctor. DOW facilitates evaluators' referrals for mental health or social services.

Residents are required to write affidavits for all meritorious applicants. A 4-hour faculty precepted block for writing at CHCC is scheduled within 1 day of BHRC. Completed affidavits are notarized and submitted to court. Residents who are called to testify in court are further prepared by BHRC faculty.

CURRICULUM EVALUATION

Residents were given 37 item pre- and posttest surveys. Surveys were administered anonymously to all resident-trainees who participated in this curriculum. Surveys assessed residents' beliefs, skills, and attitudes regarding working with torture survivors.

Survey data were encoded and entered into SPSS. Analysis was performed via paired sample *t* tests for mean-composite scores, and Wilcoxon nonparametric signed-rank test for paired data. Changes in pre and postquestions were analyzed pairwise, and through mean aggregate scores. Grouping questions into composite scores was confirmed through Cronbach's alpha testing. Montefiore Medical Center's Institutional Review Board approved this study.

All 22 PGY 2 and 3 residents participated in BHRC training curriculum between 2002 and 2005, and 96% completed surveys. At baseline, 23% of residents described previous human rights trainings and 17% had diverse prior work experiences with torture survivors. Survey results are summarized in Tables 2 and 3.

Table 2. Resident Baseline Characteristics (*n*=21)

	No. (%)
Gender	
Male	6 (29)
Female	15 (71)
Birthplace	
Within USA	14 (67)
Foreign born	7 (33)
Previous human rights training	
Yes	5 (23)
No	16 (77)
If previous human rights training, type of experience	
Pre-medical academic study	1 (5)
Medical school curriculum	3 (14)
Training for nonmedical paid work experience	1 (5)
Prior medical volunteer training	2 (10)
More than 1 type of training	2 (10)
Previous experience working with torture survivors	
Yes	4 (17)
No	17 (83)

DISCUSSION

Despite the fact that doctors have an ethical and professional obligation to evaluate and treat torture survivors, as far as we know, Montefiore's PC/SM residency program is the only one to routinely train all residents to evaluate torture survivors.

We faced several challenges in developing and implementing the training curriculum. These included the limited number of appropriate educational models, the logistics of adding another curricular piece and affidavit preparation into a busy clinical residency program, and the emotionally difficult nature of this work. To address these challenges, we adapted the DOW's training model to our time constraints by restructuring it into a 4-hour session. We facilitated timely affidavit submission by scheduling affidavit-writing time during residents' work week. In response to the emotional demands of working with survivors, we established resident–preceptor pairs and a communal precepting model to provide support and early identification of secondary trauma.

As we developed, implemented, and evaluated the BHRC training curriculum, we found that our residents' perceived baseline torture survivor work skills were limited. Although some residents had previous human rights training, few had previous experiences working with torture survivors.

Our study has several limitations. The data were self-reported from a small number of PC/SM residents who select our training programs, in part, because of prior interest in social justice. Thus, they are more likely than other Internal Medicine residents to have prior human rights experiences, be aware of professional obligations to work with survivors, and have attitudes consistent with this mission. Indeed, this heightened awareness may be why no significant changes were found in the Attitudes or Codes domain scores. Nonetheless, among these highly motivated residents only 5% initially routinely screened for torture. The residents in our study showed improvement in knowledge and self -efficacy relevant to good clinical evaluation of survivors. Only dissemination and evaluation of this curriculum can assess whether similar gains are possible in other programs.

Creating and implementing the BHRC curriculum is a first step in addressing the disparity between doctors' responsibilities toward torture survivors and their clinical training in this realm. The results presented here suggest that this curriculum is feasible to teach and is likely to achieve its educational goals. We believe that our model to teach residents to evaluate survivors can be adapted by similar training settings where organized clinical experiences are already available.[10–12] In addition, we hope that our experience might inspire other training programs that serve survivors of torture to create clinical training experiences by partnering with advocacy agencies. Further work is presently being done to assess the impact of the BHRC clinic curriculum on clinical behavior, including screening for torture survivors in primary care settings, and resident' ability to work with other traumatized populations, such as survivors of domestic violence and acts of terrorism.

Table 3. Pre and Post Training Curriculum Survey Items and Educational Domains

Educational Domains	Pretest mean composite scores (SD) or (%) percent agreement	Posttest mean composite scores (SD) or (%) percent agreement	Cronbach's Alpha
Professional and ethical codes of conduct regarding torture survivors (2 items) 1. Identifying and treating torture survivors is the professional obligation of what type (s) of providers (choose from 6). 2. 4 -part question regarding the Universal Declaration of Human Rights that was established during the Geneva Convention of 1948.	0.599 (0.174)	0.679 (0.202)	NA
General knowledge about torture (10 items)* 1. Which of the following (7) sentences is/are incorrect statement about torture as it is legally defined. 2. What is the number of independent nations where torture is systematic or commonplace? 3. Percentage of those tortured among people seeking political asylum in the United States. 4. Percentage of women who have experienced rape or sexual violence among women seeking political asylum in the United States. 5. The prevalence of torture history in randomly selected foreign born persons seeking medical care in an urban medical center in NYC. 6. The majority of doctors are aware of a history of torture in their patients who experienced it. (True/False) 7. Name the populations at risk for current or past experience of torture. 8. Almost all women seeking political asylum in the United States have a history of rape. (Agree/Disagree) 9. Four statements pertaining to the legal aspects of seeking refuge in the United States (True/False) 10. What are the maneuvers one should perform when physically examining an asylum seeker.	0.487 (0.133)	0.726 (0.119)	NA
Medical and psychological sequelae of torture (4 items)* 1. Examination of the physical sequelae of person who has experienced the 2 most common types of torture reveal the following (choose 2 out of 5). 2. The types of psychological syndromes experienced by torture survivors include (4 choices). 3. Common behavioral responses of torture survivors include (4 choices) 4. Symptoms for PTSD are grouped into 3 major symptom categories which do not include the following (choose 1 out of 4)	0.669 (0.155)	0.803 (0.119)	NA
Attitudes and perceptions of residents regarding working with torture survivors (4 items)* 1. I believe doctors should know how to evaluate torture survivors (Likert scale). 2. I am concerned about being manipulated by clients lying to seek asylum (Likert scale) 3. I feel comfortable evaluating torture survivors (Likert Scale 4. I am comfortable using the diagnostic criteria for PTSD (Likert Scale).	27.4%	51.2%	0.486
Residents' self efficacy to assess torture survivors (7 items)* 1. I believe that I know how to evaluate torture survivors (Likert Scale). 2. I routinely screen for domestic violence trauma in my medical practice. (Yes/No). 3. I know how to identify the populations at risk for a history of torture (Likert Scale). 4. I know the common types of physical maltreatment used in torture (Likert Scale). 5. I understand the psychological effects of torture (Yes/No). 6. I have used the diagnostic criteria for PTSD in the last year to assess a patient (Yes/No). 7. I routinely screen for a history of torture in my medical practice. (Likert Scale).	19.0%	68.6%	0.767

Of the 37 questions, 9 are not included here: 5 are demographic and 4 were not entered into the database as they included a term that became obsolete during the course of the training.

NA not applicable because of domain construct or too few items in the domain

**Statistically significant difference (p<.05) between the pretest and posttest mean composite scores or the pretest and posttest percent level of agreement*

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I, Eva Metalios, had full access to all of the data in the study and I take responsibility for the integrity of the data and the accuracy of the data analysis.

Conflict of Interest: *None disclosed.*

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