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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.”

Trafficking of human beings is one of the most profitable businesses in the world today with annual revenues estimated at $9.5 billion. At least 27 million and perhaps as many as 200 million people are estimated to be enslaved on our planet in 2008. 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.

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. 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. 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.

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.8

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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