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Clinicians’ Preparedness to Treat Forced Migrants

A Thesis submitted in partial satisfaction of the requirements
for the degree Master of Arts
in

Global Health

by

Tiana McMann

Committee in charge:

Professor Thomas Csordas, Chair
Professor Suzanne Brenner
Professor Bonnie N. Kaiser

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Chair

University of California San Diego

2020

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ABSTRACT OF THE THESIS

Healthcare Worker Preparedness Among Clinicians Treating the Forced Migrant Population

by

Tiana McMann

Master of Arts in Global Health

University of California San Diego, 2020

Professor Thomas Csordas, Chair

In the midst of refugee crises, the proliferation of resources and healthcare services is the cardinal focus to address the acute need of those displaced. While much data is provided regarding the volume of refugees and asylees and the necessity for medical services, far fewer information exists discussing healthcare workers and their preparedness in dealing with the acute needs of those they are treating. Of those that have, many challenges are identified in all aspects of a healthcare provider's experience of treating displaced individuals. While healthcare workers are vital to

aiding in the critical needs of refugees and asylees, this can be more effectively accomplished when they are equipped to handle the unique health needs they encounter. The current study aims to explore healthcare providers preparedness in treating refugee and asylum seeker populations within San Diego County and how the level of preparedness effects the treatment delivered. In-depth interviews were conducted to support a literature analysis. Interviews and existing literature reveal that many limitations remain for healthcare workers to provide adequate care to the migrant populations. These barriers include institutional barriers which are heavily influenced by the political climate, as well as clinical barriers. Clinical barriers result from traditional medical training and the overspecialization of medicine in the US. This thesis also analyzes the influence of increasing political hostility and targeted threats on healthcare workers as a result.

Healthcare preparedness is a topic of discussion which has gained increasing attention over recent months. While the primary focus of healthcare preparedness focuses on developing a protocol and providing resources for the heightened demand necessary succeeding a disaster, the overall scope extends far beyond disasters. In fact, amongst the most common man-made disasters, is conflict (Burkle, 2006). Conflict results in grave humanitarian crises with diverse acute and chronic health needs. Despite the scope, both right-wing conservatives and left-wing liberals are in favor of preparedness for improving domestic health security and human health. At its core, healthcare preparedness is aimed at saving lives while reducing long-term health consequences (Toner, 2017). This is mitigated by establishing the appropriate training, capacity, and resources to respond to novel, unexpected events to not overwhelm the healthcare system. At an institutional level, healthcare preparedness has made progress, notably during and immediately following the Ebola virus disease from 2013-2016 (Popescu & Leach, 2019). However, healthcare preparedness is an expensive feat with offsetting revenue not likely occurring in the short-term. As a result, most recent efforts for preparedness have been through federal programs and the Joint Commission (Toner, 2017). Some federal programs aimed at addressing this have been the Centers for Disease Control and Prevention's (CDC) Public Health Emergency Preparedness which assists public health departments in dealing with emergencies. However, since its inception in 2002, funding has significantly decreased (Toner, 2017). Similar funding reductions are witnessed in many sects of preparedness programs. Funding reductions are just one source of uncertainty that underscores the challenges of maintaining infectious disease preparedness in the existing US healthcare system. Furthermore, there remains a gap in current knowledge regarding progress in healthcare preparedness made by nonfederal agencies (Toner, 2017).

While institutional preparation remains important, an essential piece to the healthcare system is those healthcare workers who are deployed and called upon to respond when faced with unexpected, novel events. Furthermore, their training and level of preparedness is arguably the most crucial component to effectively carry out their job (Medicine & America, 2001). These individuals require the necessary training and resources to capacitate an experienced response. The healthcare workforce is becoming increasingly faced with the threat of numerous types of novel events including multiple casualty incidents and infectious disease outbreaks (Ogedegbe et al., 2012). While it is crucial to have the institutional capacity for clinicians to perform their duties, it is not enough. Rather preparedness training must extend to the individuals to allow them to respond to uncertain situations.

A situation which poses itself with consistent forms of uncertainty to healthcare workers is the current global displacement crisis. According to the International Organization for Migration, a migrant refers to “any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person’s legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is,” (Abbas et al., 2018). "Migrant" will be used throughout this paper as an umbrella term and interchangeably with ‘refugee’ and ‘asylum seeker’. Healthcare providers who care for and treat migrant populations are faced with a plethora uncertainty, including, the sheer volume of patients they must treat in any given day, the conditions in which these refugees arrive in, the novel, infectious diseases they may be exposed to, the repour of the refugees, the harassment they may receive in arriving at their site, and the imminent threats that may be directed towards them. Furthermore, there remain little federal funds to support shelters and screening programs, leaving a large burden of the funds on

states and local non-profit agencies. Preparedness for institutions, and more importantly the clinicians operating within this context should be prioritized to optimize resources in resource-constraint environments and times.

Arguably, the most valuable resource is the healthcare workers themselves. The precarious nature of the day to day operations that clinicians engage in as well as their intimate involvement in critical global health work calls for analysis on their level of preparedness in addition to what should objectively be provided. Preparedness in this context will refer to the perceived and objective capacity of healthcare workers to deliver adequate care to migrant populations based on their current level of experience, training, and knowledge (Mengesha et al., 2018). Two forms of capacity as indicators of preparedness will be analyzed, including intellectual capacity and material capacity. Intellectual capacity refers to a clinician possessing the knowledge, skills, and competencies in addition to the emotional capacity required to effectively treat migrant populations. Material capacity refers to the resources which clinicians have at their disposal to efficiently perform their job.

Preparedness at this level is highly relevant due to the growing displacement crisis. The globe is currently being faced with the largest migration crisis to date with 70.8 million persons forcibly displaced, including 25.9 million refugees and 3.5 million asylum seekers. A 2.3-million-person surge was reported in one year, a drastic increase from previous years (*UNHCR,* n.d.). This number is expected to rise as the frequency of natural disasters increases, armed conflict persists, and threats of persecution remain. In fact, in the past decade, there was a 43.3 million person increase between the years of 2009-2018. Additionally, each succeeding year is peaking at a record high with the number of forcibly displaced individuals surpassing the rate of global population growth (*UNHCR*, n.d.). This increasing global trend necessitates

infrastructure which can begin to adequately address the acute health concerns which forcibly displaced individuals uniquely experience. While the motivation of developed countries such as the United States remains biosecurity, least developed countries still lack the infrastructure to adequately care for its native populations. As part of ensuring biosecurity for its domestic borders, the United States has a rigorous resettling protocol. This procedure entails the requirement for refugees to be medically screened upon entry into the United States. This screening process represents the most intensive screening that any travelers into the US undergo (Kerwin, 2018). Additionally, the administration has obstructed the screening and admission process. As such, medical providers require additional resources to complete this process. Due to the steady increases in displaced individuals the globe sees each year, in addition to a recent reduction in federal funding, this necessitates not only a preparedness at the institutional level but an increased need for preparedness at the individual level.

San Diego County has historically represented one of the largest refugee resettling locations in the United States. From the fiscal year 2015 to 2016, San Diego resettled 3,087 refugees, 1,511 more than the previous year (Llewellyn et al., 2020). Within this context, it has also been noted that San Diego has favorable integration conditions due to the infrastructure in place, strong community collaboration, and existing cultural diversity. San Diego has four refugee resettlement agencies including Alliance for African Assistance, Catholic Charities, Diocese of San Diego, International Rescues Committee, and Jewish Family Services (Office of Refugee Coordination, n.d.). Among these, there exists a nonprofit Migrant Family Shelter (MFS) as part of a larger coalition known as the San Diego Rapid Response Network (SDRRN) (Llewellyn et al., 2020). As of February 2020, slightly under a year and a half since the shelter's inception, the Jewish Family Services MFS has served 22,522 individual asylum seekers and

9,006 family units (“JFS Migrant Family Shelter,” n.d.). These numbers speak volumes to the capacity at which San Diego, and even more specifically, this shelter operates. As a large acceptor of diverse populations, clinicians operating within San Diego should be increasingly versed in delivering appropriate care.

There is a well-established body of literature highlighting the importance of the quality of aid work that clinicians and organizations alike provide in post-crisis settings. The responsibility and ethics of becoming involved in humanitarian aid became increasingly discussed following the earthquake in Haiti in 2010 (Parmar & Greenough, 2017). While clinicians deploying to countries affected by humanitarian crises represents a unique and valuable opportunity to assist, this is not always the case without training and a general understanding of the conditions and underlying healthcare system present in the region they intend to deploy to. To effectively apply their skills, clinicians are recommended to spend extended periods of time within the local context of their deployment region. While there is an urge to assist following a crisis, most full-time clinicians can only spend two to three weeks in a region before they must return to their regular employment. However, this proves ineffective and can do more harm than good due to the adjustment that is necessary to both the availability of resources, the operations of the healthcare system or organization one is operating within, and the major cultural differences that ensue, both linguistically and socially (Parmar & Greenough, 2017). Specifically, this includes the population you will be working with, their most pressing health needs, endemic diseases and conditions, availability and quality of translators, access to crucial medicines, and any religious barriers, to name a few. Notable cases of short-term aid by clinicians being successful are those who have extensive knowledge or have participated in past experiences in the local medical context and humanitarian deployments, however, these are far fewer than the rule itself (Parmar

& Greenough, 2017). Irrespective of the time constraint that most clinicians may be faced with, there are also other conflicting barriers to care that typically require prior knowledge and training. Best practices in humanitarian aid also include quickly identifying and treating many infectious diseases that are rarely seen in the western world. Beyond the initial phases of treatment modalities, there is a crucial aspect of understanding the appropriate public health response for these communicable diseases. Prior knowledge regarding endemic infectious diseases is crucial, but extending beyond this is treatment and maintenance of this disease with severe, often untreated underlying conditions. These conditions include malnutrition, dehydration, and untreated chronic conditions.

The challenges to providing humanitarian work highlighted above underscore similar challenges that clinicians treating refugee populations regularly experience. While deployment and adjustment based on local capacity may not be applicable, there are internal adjustments required. Even so, devastating outcomes can result when providers are underprepared. Beyond the heightened numbers of refugees arriving in San Diego, decreasing amounts of political support and funding, and a lack of institutional healthcare preparedness, there remains the crucial need for healthcare providers to feel adequately trained to address migrants' ailments. Many of the challenges expressed in international humanitarian aid are exacerbated for healthcare providers treating refugees due to the defining characteristics of their environment. These characteristics include an overall uncertainty surrounding their profession. The precariousness arises as a result of the number of migrants, the acuity of their conditions, the gap in their traditional training, and the increased security threat they are faced with. On any given day, a clinician tasked with screening and treating acute conditions of refugees is unaware of the number of refugees they will be seeing until shortly before an Immigrations and Customs

Enforcement's (ICE) bus arrives with that day's detainees. Additionally, the health status of each individual drastically ranges upon arrival, with no prior indicator as to what is reasonable to be expected. Furthermore, traditional medical training has witnessed a widening gap in the number of global health careers and opportunities available, and the availability of educational opportunities to prepare their healthcare workers (Nelson et al., 2012). Finally, as previously highlighted, while national security has remained a priority within the United States, especially as it relates to an increased risk of emerging and reemerging communicable diseases, a heightened migration agenda has created tensions globally, but also within borders. While a national security agenda will continue regardless of the political party, its motivation will vary. Despite this, national security should also be considered with a humanitarian focus. Furthermore, its consequences need to be carefully considered as to how it harbors a hostile environment among national populations. As a hostile environment ensues, healthcare workers need increased preparedness to approach the environment in which they work. Due to the uncertainty of the number of refugees clinicians will be treating, the conditions they will be exposed to, the lack of inclusive medical training and the need for improved security measures, individual preparedness among healthcare workers treating refugee populations must be improved.

Methods

This current thesis is part of a larger parent study, Tracing Asylum Seekers Experience and Trajectory (TASET) led by Dr. Tom Csordas and Dr. Janis Jenkins at the University of California San Diego (UCSD). TASET aims at assessing the wellbeing of migrants, as well as the trajectories of both their geographical location and life course. The current qualitative study is an extension of TASET and examines how healthcare workers are situated within a migrant's resettlement process in San Diego, California. Semi-structured in-depth interviews were

conducted among local healthcare workers who treat and provide supportive care for migrants that are arriving from federal detention camps and proceeding through their resettlement journey. Healthcare workers interviewed include physicians of varying specialties and medical translators who play an essential role in the care migrants receive. The clinicians interviewed provide support to refugees by screening and treating migrants who are brought to local resettlement agencies. These interviews were conducted to support a literature analysis contextualizing the gap in preparedness that occurs for providers who treat migrant populations. The in-depth interviews were aimed at understanding where these gaps lie and what structural conditions may contribute to these gaps. A literature analysis was conducted using Google Scholar and PubMed querying key search terms. Key terms included: refugee health, migrant health, healthcare workers, preparedness, clinician, medical education, and political uncertainty. Political documents analyzed were excluded if they predated 2016 to compare the Current Administration to the effects of previous presidencies.

Institutional Preparedness

Uncertainty in the immediate and long-term volume of refugees

Amongst one of the greatest uncertainties that are characteristic of working with this population is the sheer number of migrants the staff will be screening and assessing. This uncertainty leads to both a reduction in healthcare workers' intellectual and material capacity. As mentioned, one of the limiting factors is the communication between ICE and the resettlement shelters. This lack of coordination and providing essential information does not cease between ICE and MFS. This extends to many participating agencies, both domestic and international, failing to distribute pertinent information at all stages of the resettlement process. One example of this occurs when refugees' health information collected in the medical screening process

received abroad is not shared with domestic agencies before they enter into the United States (Brown & Scribner, 2014). Not only does this hinder the ability to track and prepare for the number of individuals who will be arriving at resettlement agencies, but it also fails to communicate vital health information.

Immigration Polices

A factor largely contributing to the precariousness of how many refugees will be resettled within a given region is the political structure a resettlement agency operates within. As such, a lack of preparedness among healthcare workers results from current policy and funding mechanisms dictating refugee resettlement. Resettlement agencies, such as MFS, are required to estimate the number of migrants which will be admitted, the sociodemographic factors of those admitted, and points of origin (Brown & Scribner, 2014). Their having to approximate these details is due to the determination of the federal budget made by the president, typically occurring in February. The presidential determination requests funds to be allocated to resettlement agencies and is directly proportional to the refugee admissions during a fiscal year. However, resettlement agencies are required to submit a Request for Proposals for the Reception and Placement Program prior to the Congressional and the presidential determination is made (Brown & Scribner, 2014). Given that information such as the proposed refugee admissions and funding allocations by region is not conveniently disseminated to resettlement agencies, their requests are required to be roughly approximated. While resettlement agencies' ability to submit a proposal on behalf of their site is an improvement from policies in place before 2011 which limited their autonomy, the inopportune submission deadline, nonetheless predisposes them to a potentially volatile outcome. Additionally, the disbursement of grants that result from the presidential determination is contingent based on the number of newly arrived refugees within

the past 36 months of which continue their settlement in the state at the beginning of the fiscal year (Brown & Scribner, 2014). This mechanism does not consider the variability in migration patterns and the rapid influxes that specific regions experience. It is highly probable that San Diego County experiences such influxes, due to its proximity to one of the largest land border crossings in the world (Farah et al., 2020). This additionally exposes agencies to unpredictable conditions.

Political uncertainty can greatly contribute to a lack of institutional preparedness. This form of uncertainty is prominent every few years within the United States as political parties are replaced and new policies are formed. This is largely the case with domestic policies regarding immigration and the reelection of right-wing candidates. One such example is the drastic reduction in refugee acceptances. Under the previous Obama administration, the refugee admission ceiling was increased to 110,000 in 2017. However, as the current administration took office, seven executive orders related to immigration were signed and put into effect. In addition to travel bans and increased vetting for refugees from particular points of origin, the refugee admissions were immediately suspended for four months. Following this, the ceiling was lowered to 45,000 refugees by 2018, the lowest admissions ceiling since the Refugee Act in 1980 (Pierce & Selee, 2017). Additionally, at the start of the administration, there were immediate proposals to reduce funding to USAID and the US State Department by 29.7% (Hawkins & Pérache, 2017). The Center for Disease Control and Prevention as well as the National Institute of Health were also subject to reductions in funding (Harman & Davies, 2019). Despite the numerous enactments at the federal level, collective enforcement has been increasingly fragmented during this administration. At the state level, there are large amounts of variation between jurisdictions and their cooperation with federal policies. California was one such state

which rejected federal cooperation in 2017 (Pierce & Selee, 2017). The provision of healthcare is an involved process that functions within many other microsystems to comprise a broad health system. That said, it is important to understand how large scale, systematic changes affect the individual level, namely healthcare providers, and the provision of care (Mengesha et al., 2018). Healthcare providers have noted that periodic legislative changes, such as those mentioned, pose a challenge to working with and navigating the healthcare system for refugee and asylum seeker populations (Robertshaw et al., 2017). Funding as it relates to the availability of resources and the constant uncertainty of policies resulting in lack of awareness both directly relate to material capacity and intellectual capacity, respectively. While the political uncertainty that arises every few years causes shifts in migration policies and exacerbates the lack of preparedness in the adequate treatment of refugee populations, it is not the sole contributor. The fragility that arises as a result of varying politics can not contribute to the demise of appropriate healthcare. Rather, the need for alternatives in closing the gap between policy and action is required. In the case of healthcare and those who deliver it, it is seen as creating an increased individual level preparedness (Hawkins & Pérache, 2017) (Harman & Davies, 2019).

Consequences of Uncertainty in Populations

One limiting factor in the ability to prepare is the approximate number of migrants that healthcare providers will be treating overall, as mentioned. However, further complicating this is determining how many will be arriving from a particular country of origin. For example, in the fiscal year 2016, San Diego County received 588 refugees from the Democratic Republic of Congo (DRC). The succeeding fiscal years saw sharp decreases in DRC arrivals to 178 refugees in 2017 and further decreasing, remaining under 120 arrivals in the next two fiscal years. Similarly, in the fiscal year 2015, San Diego accepted 53 arriving refugees from Syria. The

following year saw a substantial increase to 779 refugees from the same country of origin (Refugee Processing Center). In a given fiscal year, there can be stark differences in which populations are arriving and from which country of origin. As such, increased arrivals and returnees challenge the ability to plan effectively (Musani & Shaikh, 2006). The number of displaced persons from a given region can drastically inform care. In being informed as to which populations healthcare providers will be treating, this better prepares them for the health demographics within the country of origin. Clinicians may then be able to analyze which conditions are endemic to that population and develop a best practice approach for treating particular diseases.

Inability to Adequately Staffing

Without the prior knowledge of the immediate number of refugees who will be arriving at a shelter, there is a great amount of uncertainty concerning staffing. Speaking to this point, Physician 2, a physical medicine and rehabilitation doctor, highlights the lack of timely communication and how this affects an agency's material capacity. One structural issue as a result of poor communication was the inability to adequately staff. "People would be arriving to the shelter at midnight, one in the morning we would get busloads when the clinic staff would have been gone. There was that issue," (Physician 2). Further speaking on this matter,

> "they always you know, have it done but the clinic staffing is absolutely impossible to staff. You know when we were seeing hundreds a night, we had plenty of staff, there were lots of people to share the load and now you don't know until the very last minute if you are getting one family, three families or thirty families and it is totally impossible to staff. It isn't that we are understaffed. That is sort of the wrong word to say. It is that staffing is impossible to do in that setting so I think that it is um. They have lots of you know sort of back up and workarounds you know, and we have on-call providers that we try to reach out to that come in. Definitely lots of people have come in at the last minute. Lots of people have done double and triple shifts when needed. It is an impossible clinic to staff. If you want to say it is understaffed, half the time it is overstaffed because you think you are getting a certain number of people and then they never show up and providers are sitting

> around not doing anything. It isn't over or understaffed. It is just plain impossible to staff," (Physician 2).

In terms of staffing and the potential outcomes within shelters, there are three possibilities resulting solely from the sheer number of migrants on a given day. The first, and best possible outcome is that a shelter is adequately staffed with healthcare workers to efficiently treat the influx of refugees. Another possible outcome is a shelter is overstaffed and have too many healthcare workers with a very low number of migrants, wasting material resources, as Physician 2 highlighted. The final, and worst possible outcome is one in which a shelter receives a large influx of migrants and is underprepared in terms of available staff to efficiently screen and treat the number of migrants, lacking the required resources. While the clinic Physician 2 speaks of has an ad-hoc protocol in place for this final scenario, other clinics may simply lack to resources to do so. These outcomes take into consideration only the ability to treat the number of individuals and do not consider the diversity of acute needs that further complicate these outcomes. When there remains consistent uncertainty in the day to day operations, this requires a greater level of preparedness on the individual level. This is similar to the rationale in training for emergency medicine physicians. Because of this same level of uncertainty in their setting, emergency physicians receive broad training which makes them suitable to work with a quick, yet effective approach in a highly austere environment (Parmar & Greenough, 2017).

Barriers in the Medical Hierarchal Framework

While uncertainty in medical settings, in general, is inevitable, healthcare providers in a traditional clinic or hospital have a predetermined hierarchy which they can rely on to pool knowledge and consult on complex cases (Kim & Lee, 2018). In the context of most healthcare settings, attendings or department heads are available for consultation at the tip of the hierarchal chain and considered the breadth of knowledge. This is due to their years of specialized medical

training beyond their intern year in addition to their increased exposure to the specific population or conditions in which they are trained to treat. This firm hierarchy is not always present in the case of humanitarian crises, and oftentimes, lead physicians are required to be the sole provider and decision-maker. However, when this hierarchy is in place, it does not necessarily align with the conditional steps needed to be met to be considered an expert. One physician revealed the intricacies of the structure of a migrant shelter in San Diego which further raises the question of how this hierarchical organization may perpetuate a lack of material and intellectual capacity. This provider recounted their initial anxiety taking on such a role. "Subsequent it was um I, I think then a little nerve-wracking being the lead physician and being responsible for supervising trainees when there were healthcare problems with adults and getting to the point where my comfort zone was with that," (Physician 1). This provider further recalled experiences where they were the only clinician responsible for overseeing shelter functions, as well as treating incoming migrants. As a highly specialized pediatrician who had not practiced clinical medicine in two and a half years, there were initial internal dilemmas. Corresponding to Physician 1's comment, Physician 2 remarked on the role as the principal decision-maker. When asked if there exists a team to brainstorm and collaborate when encountering an uncertain situation, Physician 2 stated, "not really so you are talking to the physician, I am the leader. I have to know it. You know like the interpreter, the assistants, the managers, no one else is going to know it. You can't go to them and say like how do I know if this lady is in labor? You know, you have to either know it yourself or look it up. I look up a lot of stuff because if it is something I don't know, I need to look it up," (Physician 2). Given this uncertainty that can arise, it is important to understand how this impacts the clinicians and the patients they are treating. Medical uncertainty can be threatening to patient safety, and intolerance to medical uncertainty has been shown to

negatively impact doctors' emotions, psychological wellbeing, and job satisfaction (Kim & Lee, 2018). In turn, this can result in an increased risk of physician burnout. While this uncertainty may not be able to be resolved entirely, there are clear ways to reduce its impact and better prepare healthcare workers to provide adequate care to migrants. One such way is through increased coordination and dissemination of information between governmental entities and resettlement agencies. In doing so, agencies would be briefed on the fiscal admission ceiling for migrant arrivals and therefore submit funding requests based on reasonably expected projections. This in turn prepares local capacity for the influx of migrants.

Institutional Failures

Even those organizations that are well established in the humanitarian space and have years of experience in healthcare delivery in crises have continually failed in outbreaks of infectious diseases. Médecins Sans Frontières (MSF) is a non-profit organization founded in 1971. Their mission is to provide medical care to those affected by disasters, conflict, epidemics, or lack of access to healthcare and achieve this as a worldwide entity with 67,000 members (*Who We Are | MSF*, n.d.). Yet, even with over 40 years of field experience, MSF has fallen short of its global health duty in response to both reemerging and more common outbreaks. The Ebola virus disease is one example of MSF's failure to recognize the severity of the infectious outbreak. Even in cases of infectious diseases that are still commonly seen in developing nations such as malaria, cholera, and measles, MSF has neglected the appropriate public health response required to avoid epidemics. Both the reemerging Ebola virus and the more commonly treated infectious disease failures have highlighted substantial repercussions, including considerable amounts of death (Hawkins & Pérache, 2017). Then, when narrowing the scope from specialized and experienced international organizations to individual healthcare providers, or even local

resettlement agencies, it can be expected that there may be similar failures. Providing trainings that are specific to conditions that characterize refugee populations was found to be a facilitator to healthcare workers providing care. Trainings of this sort were reported to "increase confidence in care delivery and resulting in 'more effective, evidence-based care,'" (Robertshaw et al., 2017). Intellectual capacity can be improved among providers by providing such training and avoiding potentially severe failures.

Lack of Communication as it Relates to Condition-Specific Care

A lack of communication between agencies has been identified as a barrier to preparedness in terms of how many refugees may be arriving at a given resettlement location. However, this lack of communication also contributes to uncertainty and ambiguity in the acute state that certain migrants may be arriving in. The CDC Division of Global Migration and Quarantine has current health screening guidelines for implementation at the domestic arrival of refugees in which international medical information is used to ameliorate and guide clinical care and treatment (Carrico et al., 2017). In cases where health information has been shared with resettlement agencies, oftentimes medical records may be indecipherable, making them insufficient for appropriate diagnoses. Furthermore, while some pertinent physical health information is shared, mental health information still lags behind (Brown & Scribner, 2014). The health screen that is completed overseas prior to a migrants resettlement into the United States is primarily focused on communicable disease of public health significance which includes: "active tuberculosis, infectious syphilis, gonorrhea, infectious leprosy, chancroid, lymphogranuloma venereum, and granuloma inguinale," (Taylor et al., 2014). In addition to the distress that results from conflict, poverty, and forced migration, refugees also experience psychological harm due to the increased vulnerability and prevalence of both communicable diseases and NCDs (Al-Obaidi

et al., 2015). Despite the recognition that refugee and asylum seeker populations experience sustained psychosocial trauma from their country of origin and the arduous migration journey, a comprehensive mental health assessment has yet to be implemented. That said, the resettlement process incorporates an assessment but is not designed as a diagnostic measure for mental health conditions. These crucial elements underscore the underestimation of the severity and prevalence of mental health conditions among these populations (Taylor et al., 2014). Regardless of the underestimation, it is suggested that refugees who are resettled in Western countries have increased rates of mental health conditions as compared to the general population within the country and their needs, as a result, are substantial (Mishori, 2017) (Al-Obaidi et al., 2015). Due to the acute issues and unique population, mental health delivery requires an integrated approach by institutions and healthcare professionals. However, many barriers prevent healthcare workers from adapting and providing adequate mental health care.

Healthcare encounters do not occur within a vacuum. Rather they operate within a large sphere of bureaucracy and are subject to the political climate and resulting processes (Robertshaw et al., 2017). Furthermore, the long-term refugee trajectory shows no indication of declining. In the past decade alone, there were over 40 million people forcibly displaced. Due to a history of tensions surrounding religion, ethnic groups, and geographical territory, a continuation of humanitarian crises is reasonable to expect (Musani & Shaikh, 2006). Because of the confounding factors which contribute to the uncertainty in the number of migrants needing assessment by healthcare workers, in addition to the probable increased number of displaced persons in the coming years, healthcare worker preparedness should be prioritized.

Clinical Preparedness

The diverse and acute nature of the conditions and needs which characterize refugee populations are unparalleled. These populations suffer from decreased health status, both physically and emotionally, as compared to general populations (Daniel et al., 2010). Refugees and asylum seekers often flee from traumatic, long-standing conflict. Consequently, many are originating from countries with a severely disheveled or entirely non-existent healthcare infrastructure. The majority of refugees and asylum seekers are migrating from low- and middle-income countries, where increased prevalence rates of infectious diseases are observed (Robertshaw et al., 2017). Additionally, however, shifts in the burden of disease have changed as average life expectancy continues to rise. Non-communicable diseases (NCD) have increased in low- and middle-income countries as is characteristic of Syria, Iraq, and Afghanistan who are experiencing higher rates of diabetes, hypertension, and obesity (Parmar & Greenough, 2017). Predicting the diversity and acuity of health issues is problematic as the distribution of disease is frequently shifted. In addition to the increased incidence of NCDs, countries in the Middle East have witnessed a drastic increase in conflict-related morbidity and mortality. Between 1990 and 2015, morbidity resulting from violence rose by 850%. Within Syria alone, conflict-related factors shifted from the 19th cause of morbidity and mortality to the first factor within ten years (Matlin et al., 2018). Pre-existing conditions, coupled with the lack of access to care on their journey results in unmanaged, exacerbated cases. While complicating pre-existing conditions, the precarious journey which migrants make to their country of arrival also exposes them to further exacerbations. Poor hygiene, crowded detention centers and camps, malnutrition, and dehydration are common complications refugees, and asylum seekers encounter (Lam et al., 2015). Psychological trauma is another typical health presentation among this population due to

the conditions they flee from, as well as their encounters during migration. Furthermore, gender-based violence (GBV), most commonly reported as sexual or physical violence occurs at higher rates amidst this group. This is also exacerbated by the complete lack or limited access to contraceptives or reproductive services (Robertshaw et al., 2017). Due to this, women and girls represent a particularly vulnerable population with unique needs beyond that of typical communicable and NCD disease treatment. Each of these components to refugees' health status creates an extremely diverse and complex approach and treatment protocol. A critical understanding of endemic diseases, social determinants, and an adequate public health response allows healthcare workers to feel prepared to address refugees' health concerns and also highlight their specific needs.

Sexual and Reproductive Health

Women and girls comprise nearly half of any refugee, asylee, internally displaced, or stateless population (Refugees, n.d.).With the increased level of care they need, women and girls often introduce complications to the typical standard of care and levels of acuity. Their level of care is typically more complex and requires expertise that exceeds what is acquired in a typical medical education or setting (Mengesha et al., 2018). One such challenge that health professionals encounter is physical injuries such as female genital mutilation and injuries resulting from torture. Other issues particular to this population include rape, sexual abuse, unplanned pregnancies leading to unsafe abortions, and sexually transmitted infections, all while the topic is viewed as taboo in many cultural frameworks (Mengesha et al., 2018). Physician 1 eluded to the unpreparedness felt when presented with one such case, raising the question of whether any clinician, in particular, is well equipped to treat migrant women. In an in-depth interview, Physician 1 revealed they were "…completely medically and emotionally unprepared

to deal with it," referring to a woman who had been sexually assaulted (Physician 1). These conditions and the challenges providers face when addressing them have shown to be especially problematic and intrusive and have led healthcare workers to feel underprepared, or oftentimes, unequipped to effectively address the reproductive health needs of migrant populations (Robertshaw et al., 2017) (Chiarenza et al., 2019). This is partly due to specific information related to the needs of migrant women not being readily available to providers (Kurth et al., 2010). In a study conducted among healthcare professionals who regularly treat migrant populations, it was found that upwards of a quarter of the sample reported low or very low knowledge of migrant women's sexual and reproductive health (SRH) needs and a slightly lower number of healthcare workers responded with low or very low confidence in their ability to provide adequate care. However, those who did report confidence in their ability to discuss and provide SRH to these populations had substantial prior experience in SRH provision (Mengesha et al., 2018). These factors combined introduce the necessity for additional training that healthcare workers require to adequately deliver SRH to migrant populations. This is increasingly the case for SRH. Limited knowledge and training among healthcare providers have been shown to contribute to an underutilization of SRH by migrant populations (Mengesha et al., 2018). To better prepare and allow healthcare workers to anticipate conditions of especially vulnerable populations, information sharing would be beneficial. Additionally, while SRH trainings bolter healthcare workers' confidence in provision, this is largely absent. Unfortunately, providing this training is not commonplace, even with the most at-risk subpopulations. The UNHCR has also recommended providing this information to resettlement agencies to ensure that the unique forms of support are in place for victims of GBV (Brown & Scribner, 2014).

Forms of support could include gender-appropriate care with specialized clinicians on staff to prepare for the complexities of such cases.

Language as it Permeates Mental Health Conditions

A more evident barrier that presents itself between refugees and providers is the distinct language differences. While interpreters may be a practical solution, they may not always be available, and there are a variety of other challenges that need to be considered with this. Physician 1 points to some of these intricacies and the lack of trust they had in the interpreter's ability to communicate vital information. MFS has access to UCSD's interpreter service, yet the quality and duration of time waited poses challenges. "…getting Russian interpreters can take 20-30 minutes sometimes and um the Haitian interpreters are awful. My French is better understood by the Haitians than the interpreters or the interpreters don't speak good enough English to understand me and I have to correct them. My French is not that good, if I'm having to correct you because I know you're doing it wrong, that's a problem here, (Physician 1). An additional consideration are the negative feelings surrounding the difficult communication barrier being projected onto migrant patients by clinicians (Kurth et al., 2010). Closely linked to language barriers are cultural differences, especially as they relate to mental health. Adapting to idiosyncrasies can pose a challenge for healthcare providers. An interpreter who provides supportive medical care to migrants at resettlement agencies by serving as their "voice" touched on the challenges mental health can pose.

> Well, I think the mental health component has been challenging, but feel in some way it's kind of a special calling of mine. I don't know… I started working with the psychiatry team at the free clinic so I think that even though I feel it's probably the most challenging part of the job, working in the mental health area, I also think it's one thing I feel kind of called to do or I have a way to listen and be able to convey the experiences people have in mental health. But I think it's hard to hear people talk about violence as such a ubiquitous part of their lives, that's hard, so I feel maybe although I was prepared somewhat for that being,

> having mental health in the free clinic, but that is a hard part of it; that is a hard part of it, (Interpreter 1).

Also closely related to cultural and linguistic barriers is the differing explanatory models of disease that healthcare workers must recognize and address (Mishori, 2017). As a result, establishing a trusting relationship with migrant populations is a time-consuming feat and often frustrating for providers (Al-Obaidi et al., 2015). Interpreter 1 also describes these differences in working with this unique population. “It’s a different kind of medicine for the clinicians and it’s a different kind of you know, vocabulary and way to describe it for the interpreter because they’re usually telling us a story of something that happened rather than reporting symptoms,” (Interpreter 1). Furthermore, none of these barriers begin to address the added challenges healthcare providers face when addressing mental health concerns among children, which requires an individual approach. While each of these obstacles to mental health care exists, healthcare workers have a positive response to implementing adequate care at the acute stages of refugee resettlement. However, equally stressed is the importance of training clinicians at refugee resettlement agencies to recognize and begin to address some of the barriers that consistently present themselves.

Addressing the Experience of Torture

Intending to improve capacity among healthcare providers and their ability to address specific conditions, the Office of Refugee Resettlement agency offers additional training and assistance to those who treat migrant populations (Al-Obaidi et al., 2015). The National Partnership for Community Training (NPCT) aims at developing best practices of treatment for refugee populations, especially the highly vulnerable survivors of torture (U.S Department of Health and Human Services, 2012). Torture is a commonly occurring experience for refugees and negatively impacts their mental health. It is estimated that there are 1.3 million refugees

living in the United States who are survivors of torture. Despite these high rates, only 3% of refugees who had experienced some form of violence relayed this information, and none had been asked by their healthcare providers (Mishori, 2017). This can be the result of the lack of a trusting doctor-patient relationship, a lack of knowledge providers may have about violence amongst this population or are unaware of how to appropriately address this major health concern.

Overspecialization as a Barrier to Treating Diverse Conditions

Tying directly into their medical training is the overspecialization and underutilization of general practitioner skills. This systematic limitation has created barriers for providers to deliver comprehensive care. Traditional medical education within the United States is set around one year of a general internship after medical school and a specialized residency program that follows. Each residency program trains clinicians in-depth knowledge and practices specific to their field. Beyond completion of their residency, physicians can then choose to subspecialize within their chosen field, becoming the most highly trained practitioner within a specified area of medicine. While subspecialists can provide targeted treatment towards particular conditions, their practice often requires greater infrastructure to effectively apply their skills. Within the context of resettlement agencies, this infrastructure usually is nonexistent. However, general practitioners are typically recognized as having comprehensive training which makes them more suited to address diverse cases (Nelson et al., 2012). In one in-depth interview, a physician regularly working with and screening migrants as part of their resettlement requirement revealed the challenges that may come with being highly specialized in a particular area of medicine. "…Just the previous 15 years I had been working primarily as uh a clinical and metabolic doc which puts you in a very specialized place where I didn't, I did primary care for my patients that

had rare diseases and I was briefly comfortable seeing both kids and adults in that context um but had not really worked as a straight pediatrician for a number of years," (Physician 1). When further questioned about the transition into regularly treating diverse patients with varying health concerns, Physician 1 disclosed, "I think it was, probably if I'm truthful it was anxiety-provoking at the beginning whether or not um I would be able to make it work um you know whether I still have the skills and ability to do it…" (Physician 1). This raises the questions as to whether a traditional medical education and the highly specialized system is sufficient for medical providers to integrate themselves into global health or similarly, humanitarian work. Similarly, Physician 2 attributed a portion of their under-preparedness to their specialization. "And what am I underprepared for? You know, a lot of times stuff comes up which is like regular, like what you think of as like, kind of a simple question or routine problem but because I am not boarded in family practice, like I wouldn't know the answer to that question. So, you can never know everything that comes your way because like I said the problems are varied and even people I think who are boarded in family practice sometimes don't know everything that comes their way. Sometimes there is really simple stuff like every time I go to the shelter, I have to look again at certain protocols because I would be completely be lost without the protocol or if it is something really simple like what is the antibiotic for Otitis media. Like I don't know that. I am not family practice. I don't treat Otitis. I have to look it up every time. You know simple stuff like that I would be underprepared for," (Physician 2). However, further highlighting the importance of additional training for healthcare workers, is the decreased knowledge and experience general practitioners possess with many acute, specialized conditions. One such example is mental health. At the early stages of a refugee's resettlement, general practitioners are usually leading the screening and assessment of the mental health needs of their patients. However, prior

research has shown that these practitioners have less experience, knowledge, and exposure to mental health than specialized clinicians (Al-Obaidi et al., 2015). Beyond those conditions of mental health, healthcare workers may encounter patients whose physical health lies across a diverse continuum. Characteristic of this are communicable diseases. A skill that practitioners should hold is recognizing symptoms of diseases that are endemic to their migrant patient's country of origin. For example, malaria should be ruled out in cases of fever and similarly, tuberculosis should be screened for in the cases of distinguishing symptoms. Refugees are at an increased risk of tuberculosis reactivation within the first few years of their resettlement (Mishori, 2017). These differential diagnosis modalities are not typical amongst native populations and may be unfamiliar to practitioners. While specialized care is necessary for complex and acute cases, it is typically recognized that the more general a clinician's exposure has been, the more versed they will be in treatment. General practitioners also have experience working with underserved populations and the ad-hoc treatment that this entails (Walden et al., 2017). Despite this fact, the knowledge of the unique health factors that constitute refugees is necessary. Guidelines for clinical practice in treating refugee patients are typically unavailable, although deemed by healthcare providers as valuable (Robertshaw et al., 2017). Most well-established international organizations, such as MSF have additional training programs that providers can participate in before deploying in humanitarian crises. Many organizations require this of their accepted healthcare workers as well as a minimum deployment requirement (Parmar & Greenough, 2017). Unfortunately, this is still not the case for clinicians who treat refugee populations domestically, despite the presence of many of the same conditions. Similarly, the NPTC offers additional training and technical assistance specific to those who are working with migrant populations, however, it is unrequired by most agencies.

Diverse conditions are complicated by a diverse treatment protocol. Often, clinicians who are faced with NCDs, are tasked with treating under a constrained environment and resources. Globally, the burden of NCDs is rising, with notable increases in low and middle-income countries. Attention and screening protocol among refugees seeking resettlement has disproportionately, yet with well-founded justification, focused on communicable diseases. However, with increased prevalence rates of NCDs occurring within common points of origin for refugees, there requires greater attention to addressing these conditions (Yun et al., 2012). Of those NCDs that have been routinely integrated into the standard health assessment for refugees include diabetes and hypertension screenings.

Critique

Medical training

Altering clinical education and opportunities are distinctly significant in achieving improvements in healthcare delivery (Medicine & America, 2001). Despite the large increases in migration and the increasing prevalence of communicable diseases globally, the traditional medical curriculum that currently exists may be insufficient to prepare healthcare workers to deliver the necessary care. A notable shift speaking to this point is the requirement for clinicians to have increased knowledge of emerging and reemerging tropical diseases while prioritizing cultural competence in their treatment. As such, a large burden is being placed on the United States medical system to assist medical trainees in entering into the global health workforce (Drain et al., 2007). Given the dynamic nature of the healthcare system and the health needs of the global population, there is an increasing emphasis on the addition of new skills to accommodate such changes (Medicine & America, 2001). The specialized healthcare training model for physicians as previously described is one area that requires reformation to successfully

train clinicians, especially those who plan to work with migrant populations. While altering the curriculum itself is crucial, the approach and organization of a clinician's education also require attention to better prepare trainees. One suggestion is creating a more interdisciplinary approach in which training programs incorporate the knowledge and expertise of many specialties, rather than the segregated programs that currently exist. This is becoming increasingly relevant as the burden of disease continues to shift and both migrants and native populations alike present with complex chronic conditions. In addition, as crises and the time individuals go without seeking medical care are prolonged, a double burden of disease is expected as physical and mental conditions remain untreated (Chuah et al., 2019). These factors further elucidate the need for a comprehensive health response requiring a breadth of knowledge, or alternatively, a multidisciplinary team approach, however the latter requiring increased material resources. While this suggestion remains, altering the specialized medical training program that functions has proven difficult in the past due to the specialized structure and hierarchical framework that medical education models (Medicine & America, 2001).

Experiences that are gained in limited-resource settings differ from what medical professionals gain in their traditional education (Abi Nader & Watfa, 2017). This difference is also witnessed when working with multicultural populations versus working in a limited resource setting abroad, highlighting the benefits of various training opportunities (Drain et al., 2007). While research in such constrained environments has led to a breadth of knowledge surrounding care in least developed countries, current research and funding have focused on the diseases which disproportionality impact high-income countries (Drain et al., 2007). Clinical work in resource-constrained environments is just one pathway that healthcare providers can specialize in as a part of their training. While this experience and exposure can greatly impact the trajectory of

their career and enhance their formal training, there is a widening gap between the number of available opportunities and interest (Nelson et al., 2012). There currently exists a growing field of global health, and as the field expands, many practitioners and those in training are becoming increasingly interested in obtaining educational opportunities. However, the opportunities available to those interested are lacking, both in availability and also the breadth of those currently offered. Despite the acknowledgment of this gap, it is also very well understood that without the necessary guidance, global health training can have detrimental effects (Nelson et al., 2012). That said, those who partake in opportunities may lack the necessary guidance required to effectively prepare them for work in global health. The incorporation of successful opportunities can take the form of formal courses in medical school, residency programs, mentorship, elective time, and global health fellowships post-residency, to name a few. The benefits of participating in global health training directly relate to the care delivered by healthcare providers who treat refugee populations. In fact, one of the benefits for medical students who engage in global health educational opportunities is improving their ability to adequately provide general healthcare to vulnerable populations, both domestically and abroad (Nelson et al., 2012). However, while the benefits for trainees include differential diagnosis skills and being faced with imported communicable diseases, incorporating trainees too early can raise ethical issues and be exploitive in nature (Al-Obaidi et al., 2015). That said, even those who do not continue to work with migrant populations, will still greatly benefit from their acquired skills. In turn, this promotes the local healthcare systems and population. In fact, trainees who have completed international experiences either within medical school or residency programs are more likely to enter general practitioner careers (Drain et al., 2007). Furthermore, global health trainings do not cease within medical school but should be developed throughout a clinician's career to ensure they are

adequately prepared for the line of work. Beyond medical school, residency programs are incorporating global health curriculum into three to four-year programs to prepare those interested in careers in the field. Finally, at a more advanced level, fellowships in various specialties are offering a dedicated global health curriculum to develop relevant expertise. At its fundamental purpose, by enhancing traditional medical education with global health education, clinicians gain the exposure to, "diverse pathologies, improve physical exam skills by decreasing the reliance on laboratory tests and imaging, enhances awareness of costs and resource allocation in resource-poor settings, and foster cultural sensitivity," (Nelson et al., 2012). Applying cultural sensitivity into healthcare is integral to improving health outcomes. Cultural approaches to healing can vary largely between ethnic groups. This interaction between cultural competency and treatment has been well established within ethnomedicine (Drain et al., 2007). Further, culturally competent care influences treatment adherence and better health outcomes for patients (Vaughn et al., 2009). Due to cultures' heavy influence in health and healing, integrating refugee health into traditional medical programs will allow institutions to provide enriching opportunities for trainees, as well as increased services that are available to traditionally underserved groups. Further benefits include clinicians developing an understanding of global public health issues and an increased desire to work with underserved and multiethnic groups. In fact, similar to students and residents entering general practitioner medicine, trainees having engaged with international opportunities are more likely to obtain a degree in public health and take part in community service (Drain et al., 2007). Overall, there is an increasing recognition that medical professionals are needed to fill the increasing number of global health careers. As such, there is also increasing recognition of the need to prepare those who intend to enter global health careers. While there remains interest from clinicians and trainees, there exist numerous limiting factors.

Healthcare workers who are treating refugee populations are undoubtedly working within the realm of global health. They are regularly exposed to many of the exact competencies that formalized global health curriculum aims at preparing clinicians for. This includes the presentation of diverse conditions, working directly with vulnerable, underserved populations, applying culturally appropriate care, limited access to resources, and operating within a highly politicized environment. Yet, many of those who volunteer or are paid healthcare providers for resettlement agencies, have had no additional training to prepare them for this unique line of work. Clinicians would be better equipped to address the health needs of underserved populations, such as migrants with a thorough understanding of global health (Drain et al., 2007). Furthermore, due to their intimate exposure to infectious diseases, healthcare workers within the migrant context need to be well versed in the appropriate public health interventions that are fundamental to working with humanitarian populations, yet few possess such knowledge. In fact, among medical students who have completed curriculum in global or public health, about a quarter have reported that there was inadequate instruction (Koo & Lapp, 2014). Furthermore, the core curriculum which is required of those receiving a public health degree may perpetuate an already divisive relationship between clinical medicine and public health. This idea of two separate disciplines is made apparent through separate medical schools and schools of public health (Koo & Lapp, 2014). While receiving a public health education is important, not recognizing its applicability to clinical practice is a misuse and failure of educational programs. Similar feelings of inadequacy or under-preparedness in the appropriate global public health response is further noted in Physician 1's comment regarding their lack of knowledge about approaches to highly infectious, recognizable diseases. This doctor felt conflicting emotions, describing the feeling of being both "equipped and not equipped" to manage a measles diagnosis.

On the one hand, they were easily able to recognize the distinctive condition, and in this case, felt well equipped based on their specialty as a pediatrician. However, this was muddled with the feeling of being unequipped in addressing the public health side of a highly infectious agent. Overall, there is a strong consensus validating the importance of global public health knowledge in clinical practice. In fact, further validating the benefits of their obtaining a public health degree, Physician 2 stated, "Um, I am very good at processing large groups of people efficiently. I am well prepared to do public health and I am well prepared to sort of triage and isolate and categorize the acuity of you know, people," (Physician 2). To better streamline the integration of both clinical practice with population-based knowledge and application, graduate public health degrees should be implemented within medical curriculum, rather than an isolated entity. Additionally, while this greatly improves education for clinical students, this in and of itself is insufficient as it limits the discourse to institutions. Institutions must then possess the capacity to implement effective public health education into already limited didactic years for clinical students (Nelson et al., 2012). Providing accessible online modules for students during their clinical years creates applicable knowledge, as it relates to actual patients. This novel approach was implemented among medical students who had completed rotations at a safety net hospital in Harlem and resulted in a significant increase in their public health knowledge. The curriculum was included in response to the same set of students responding that there was a gap in their knowledge and preparedness to work with underserved populations. The acknowledgment of the gap in their education also coincided with the willingness to engage in additional public health education. This adaptation of publicly available public health curriculum may then be implemented as a requirement of previously practicing clinicians who intend to work with

migrant populations. This not only prepares those working with migrant populations but further prepares all clinicians who encounter underserved communities.

As previously noted, the experiences gained from a formal medical education largely differ from that of refugee-based field experience. Issues surrounding politics, climate, gender norms, and finance become implemented into standards of care for refugee populations, topics that are not typically considered in idealized, traditional patient settings (Abi Nader & Watfa, 2017). (Parmar & Greenough, 2017). Residents deployed to volunteer in refugee populations have noted that even with experience in working with underserved populations and the resulting exposure to a variety of cases, the variation in presentation of diseases in the field was far more diverse (Abi Nader & Watfa, 2017). Specific to migrant women and their health needs, clinicians have recognized the importance of additional knowledge with regards to this population's health, specifically SRH. Knowledge gained during undergraduate and postgraduate training has been insufficient in preparing clinicians to deliver quality SRH services (Mengesha et al., 2018). In fact, the healthcare providers who were most comfortable delivering SRH care to migrants were those who had substantial prior experiences. Similarly, Physician 1 emphasized their competency to migrant care provision was due to their independent roles and migration history themself. "…Actually, I was probably as well qualified if not more qualified than many to take care of migrants because of a lot of the previous training I've had and actually sort of some of the, the roles that I've taken previously, the fact that I am myself a migrant," (Physician 1). This argument truly underpins the premise that traditional medical education is insufficient for healthcare workers to effectively treat migrant populations, both as it relates to SRH, but in most aspects of healthcare provision. Overall, there is a need to incorporate cultural competency

training within institutions as well as the core foundations of what working with refugee and migrant populations entails.

Medical training typically occurs within a relatively controlled environment, as compared to refugee clinics. Furthermore, clinical experience is earned through ideal settings typically in a hospital or clinic with adequate supplies and equipment to carry out an entire standardized patient visit. One such training mechanism for medical students as well as increasingly so in other disciplines of medical training is the Objective Structured Clinical Examination (OSCE). An OSCE is meant to deviate from more established measures of assessment such as written coursework and assessment in practice (Fidment, 2012). However, an OSCE relies on students applying their skills within a simulated environment and set conditions. While this is not the sole clinical training that future providers receive, it is an environment that trains them to look for specific signs and symptoms in a given population and how to then address it with the necessary resources. A simulated experience and a plethora of resources are far from what clinicians have at their disposal when treating migrant populations.

Domestic medical education does not in and of itself sufficiently prepare healthcare workers to effectively treat migrant populations. There remains a gap in their intellectual capacity, which is necessary to provide comprehensive, culturally sensitive care under constrained settings. Improvements in medical education would not only help clinicians develop the knowledge needed for migrant populations, but it would also increase their ability to provide improved care to vulnerable groups domestically.

Examining how Hostility Relates to Capacity

One other such confounder to preparedness among healthcare workers is the political uncertainty, its creation of a hostile environment, the increase in targeted attacks on healthcare workers, and how each of these is related. The topic of increased threats towards healthcare workers and the effects it has on their ability to carry out their work effectively has not been heavily considered. However, understanding what contributes to a healthcare worker's willingness to respond is crucial in preparedness efforts. Furthermore, past research shows the importance of understanding how threats are perceived and how these perceptions in particular play a role in the willingness to report among providers (Balicer et al., 2011). Threats against healthcare systems have been increasing, both domestically and abroad. Despite the protection under international law, targeted attacks have been witnessed in countries with internal conflicts, such as Syria, West Bank and Gaza Strip, and Iraq, in order of frequency of reported attacks. Despite underreporting, 2016 accounted for 302 attacks in 20 countries facing a crisis. This equated to 418 deaths and 561 injuries among healthcare workers (WHO, 2016). As these attacks increase in humanitarian crises abroad, it becomes highly relevant to understand how a hostile political environment domestically, threatens the safety of healthcare workers and may contribute to a lack of both material and intellectual capacity.

Historically, security has been highly politicized in the context of Homeland Security and protecting the borders of the United States. As of recently, the primary discussion surrounding national security has taken the form of protection from the illegal movement of people. In addition to the drastic cut in accepted refugee admissions, the current administration has also internally removed upwards of 220,000 people, separated families, and broadened the scope of what constitutes a removal to include those who do not have a criminal record or pose a threat to

society (Pierce & Selee, 2017). Domestically, this, alongside other extreme policies, has created a hostile environment and placed armed power and violence as the defining features of American culture. Violence has become commonplace and no longer raises moral or ethical dilemmas as acts of lawlessness and support for militarized states continues to rise. Much of the discourse surrounding this day and age's political uncertainty has disproportionately targeted vulnerable groups, including refugees, undocumented immigrants, and racial and religious minorities, all while empowering extreme racism and xenophobic attitudes (Giroux, 2017). A recent surge in such inflammatory discourse has led to a broader epidemic of hate crimes, in which some states found that a quarter of perpetrators of such crimes cite Donald Trump. Further supporting the claim that hate crime has risen as a result of the most recent election is the atypical rise in attacks occurring during the fourth quarter of 2016, a time which has consistently reported lower rates. Overall, Trump's election has been associated with a statistically significant increase in hate crimes (Edwards & Rushin, 2018). In response to such maltreatment of marginalized groups, many healthcare advocacy groups have arisen to support health and the proper treatment of migrants. Some organizations include Doctors for Camp Closure, with protests occurring in San Diego County in early May of this year (*NewsWeek*, 2020). Other protests involving healthcare workers advocating for improved conditions for migrants have occurred in San Diego, Boston, San Francisco, and Washington D.C., to name a few (*NBC,* 2019) (*Common Health*, 2019) (*San Francisco Chronicle*, 2019) (*Power Post,* 2019). Politically driven protests often can give rise to the opportunity for threats of attacks by opposing groups, whether this is verbal, physical, or other forms of harassment. Given the increasing political uncertainty that has led to national hostility and the opposition of immigration, healthcare workers require increased preparedness. In one study measuring healthcare workers willingness to report to work following a radiological

dispersal device, one of the scenarios in the Department of Homeland Security National Planning Scenario, a large proportion of workers surveyed an unwillingness to respond to work if asked to do so (Balicer et al., 2011). However, an increased percentage of these workers were willing to respond with various forms of additional training, pointing to the importance of providing such preparation. This impact directly translates to material capacity and an increased workforce in dire times. Preparedness among clinicians is needed to understand the risks of working with and treating vulnerable populations, especially those migrants who have, unfortunately, become highly politicized. Considering that fear and illness are large risk factors for aggressive behavior, learning to cope with the increased risk of attacks and completing training concerning recognizing and mitigating such risks should be a priority (Stephens, 2019). This topic is currently understudied but is pertinent due to the rate at which migration and migration discourse are framed within today's society.

Conclusion

The trajectory of global migration and the increased threat that emerging and reemerging communicable diseases are posing and will continue to pose on the healthcare system requires increased capacity amongst the invaluable resources. The novelty of both of these factors calls for an increased preparedness amongst both our institutions, but more importantly so, among our healthcare providers who are delivering care. Current preparedness is further confounded by issues surrounding national policies, as well as international laws. More frequent attacks and threats of violence on health systems and healthcare providers themselves have been evidence of this. Furthermore, preparedness for humanitarian crises has been focused on the immediate aftermath of an event, rather than in preparation for disasters to reduce vulnerabilities, underscoring the absence of current capacity (Musani & Shaikh, 2006). This is largely due to the

lack of an immediate economic return in preparedness efforts. The resulting outcomes of a lack of preparedness among healthcare workers not only affect themselves, but also the populations they treat, and the healthcare system itself. Uncertainty in their line of work, the inability to effectively communicate with their patients, the unavailability of educational opportunities to further prepare themselves, and constant legislative changes have led to increased burnout and work-related stress. Further exacerbating these contributing factors is the stigma that exists surrounding seeking mental healthcare services among providers (Baker & Sen, 2016).

A multifaceted approach is required to improve the capacity of healthcare workers, and as a result, the provision of healthcare to migrants. As the displacement crisis worsens annually, this becomes increasingly significant. Forced migrants represent a population that is unpredictable in their numbers, conditions and their position within politics. To alleviate some uncertainty, additional capacity is needed among the providers who are working with these vulnerable populations. As was previously highlighted, institutional preparedness directly relates to individual preparedness among clinicians. Because institutions operate within political spheres, they are subject to sporadic alterations in their material resources. Material resources, such as funding, impact individual providers. Similarly, intellectual capacity in the form of the ability for institutions to predict and plan is hindered. This hindrance then translates to issues with adequate staffing and how to prepare for unique populations of migrants. Even institutions that are seemingly prepared, such as MSF, are susceptible to devastating failures when proper knowledge is not deployed in given situations. These points highlight the significance of possessing increased capacity, both material and intellectual. Intellectual capacity among individual healthcare providers can be accomplished through a thorough understanding of global public health. These skills tie into the treatment of migrants, both in recognizing their unique

health needs, but then further addressing them in appropriate ways. Integrating such trainings into the current medical curriculum would improve the preparedness of clinicians intending to work with migrants and other underserved groups, as well as simply produce better-equipped, competent providers overall.

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