Journal of Student-Run Clinics
Original Study

Student Perspectives While Serving Asylum Seekers: A Pilot Study

Kristiana Hanna, MD[1]; Divya Dasani, MD[1]; Aishwarrya Jayapal[1]; Sapan Shah, MBA[1]; Octavian Adam, MD[2]

[1]Albany Medical College, Albany, New York, USA
[2]Department of Neurology, Albany Medical Center, Albany, New York, USA

Corresponding Author: Octavian Adam, MD; email: adamo1@amc.edu

Published: December 23, 2023

Abstract

Background: Medical student-run asylum clinics, which support asylum seekers with medical/psychological evaluations provided by asylum clinics, have significantly expanded in the United States in the last ten years, but minimal data reviews the impact of a program like this on the professional development of providers and students. This study analyzes how student participation impacts cultural competency and professional adeptness.
Methods: Fifty-eight CDAC (n=26) and non-CDAC (n=32) participants were surveyed on demographics, comfort, and experiences interacting with asylum populations, as well as philanthropic characteristics of altruism, empathy, and compassion. Data collection and analysis were conducted using Qualtrics, R, and non-parametric testing (Mann Whitney U test, Fisher's exact test).
Results: Those who participated in CDAC endorsed greater overall experience interacting with asylum populations (p=0.01), particularly serving refugee populations (p=0.004) and having difficult conversations about physical and mental trauma (p=0.02). CDAC participants also scored higher on select measures of altruism and empathy.
Conclusion: Participation in service-learning programs is important to medical education and practice, particularly in primary care. CDAC offers a unique learning opportunity for clinicians to gain cultural competency skills while providing vital assistance to marginalized populations, even for those with no prior formal training.

Introduction

In the last twenty years, medical student-run free clinics have proliferated in the United States, often associated with academic institutions, and designed to provide medical services to poor or uninsured patients. These clinics have been shown to play a positive role in both improving patient outcomes and enhancing student professional development.[1,2] This model of utilizing learners to address gaps in care for underserved population has more recently extended to the refugee population. A student-run, interdisciplinary organization at Albany Medical Center (AMC), the Capital District Asylum Collaborative (CDAC), has strived to support refugees and asylum seekers from across the world with pro bono medical and psychological evaluations since its inception in 2015, with medical students serving as scribes for client evaluations to be used in immigration court hearings.[3]

Refugees, many of whom have endured immense physical and psychological suffering, may present in medical offices not only with evidence of physical and sexual trauma but also a myriad of mental health conditions associated with prior trauma.[4] Specifically, about a third of asylum seekers presenting to these clinics are torture survivors, with the remainder typically facing trauma in the form of forced displacement, manual labor, violence, detention, and more.[5] Understanding the unique circumstances of this

diverse group of individuals is crucial for providing the medical, psychological, and social support that most appropriately meets their needs. Beyond this, there are a plethora of learning opportunities for medical professionals and medical trainees when working with refugees, particularly in navigating working with patients of different identities, languages, and backgrounds as well as practicing trauma-informed care.

While existing research has demonstrated these clinics are highly effective at increasing the success rate of patients gaining asylum, it is largely unknown how the process involving evaluations and accompanying affidavits impacts medical trainee and physician experiences and perspectives about marginalized populations, the art of medicine, and their ability to provide healthcare.[6]

Integration of refugee health and advocacy training materials into medical education has gained momentum across academic institutions over the past decade. Clinicians frequently cite cultural and language barriers as main challenges to effective patient-clinician communication, and specific training in cultural competence even prior to graduate medical education has been linked with improved patient communication and outcomes along with reduced patient disparities.[7] Based on this evidence, the Association of American Medical Colleges (AAMC), has stated medical students should be able to effectively assess the "psychosocial-cultural influences on health, disease, care-seeking, care compliance, and barriers to and attitudes towards care" as well as communicate effectively with individuals from a vast range of ethnic, cultural, and socioeconomic backgrounds.[8] Experiences that would allow medical students to closely interact with unique populations, such as refugees and asylum seekers, may have the potential to enrich trainee communication skills and general cultural sensitivity, the basis behind implementing refugee health training in academic curricula. One study examining students who provided healthcare navigation services for displaced refugees indicated students participating in this program had improved scores for measures such as understanding refugee perspectives, comfort in communicating across language barriers, and ease of communicating with individuals of different cultures.[9]

Additionally, another study evaluating the impact of an elective refugee health course on the perceptions of participating pre-clinical medical students found that students who voluntarily participated in this course demonstrated a more pronounced awareness of the cultural factors influencing patient care, were more likely to indicate feeling at ease when interacting with patients born outside of the US, were more comfortable with obtaining a sensitive patient history involving trauma, and were able to better understand the mental health concerns of refugees.[10]

Aims

The specific impact of participation in an asylum clinic on medical students' professional growth is largely unknown and is a large area for future advancement. This study aims to compare experience and comfort working with culturally diverse populations, and the qualities of altruism, empathy, and compassion in those who participate in CDAC versus those who do not.

Materials and Methods

Participants

This was a cross-sectional, observational pilot study of 58 individuals from AMC who were recruited between January 2021 and May 2021. The survey was distributed to the entire AMC CDAC student population (62 students), with a 42% response rate (26 students). Controls were recruited from the non-CDAC AMC student population, with a final sample of (32 non-CDAC students.) There were over 500 non-CDAC students, so to keep the populations matched, non-CDAC surveys stopped being collected after hitting 32 to match a similar number of CDAC responses received. The research was reviewed and approved by the institutional review board.

Inclusion criteria consisted of full-time allopathic medical students currently enrolled at AMC. The CDAC AMC population were considered those actively involved as volunteers who were up to date on the required training. The non-CDAC AMC population was included if they did not have any prior experience with CDAC. There

was no exclusion based on gender, race, or ethnicity of participants. Participation was voluntary.

Measures

Surveys were created via Qualtrics (X4, Qualtrics International, Inc., Seattle, Washington) with a mix of quantitative and qualitative questions and were distributed via email to CDAC and non-CDAC participants. Questions assessed demographics, experience, philanthropic qualities, and cultural competency with populations different from their own. The experience survey consisted of 7 questions that assessed the amount of experience working with refugee/asylum seekers and survivors of physical/mental trauma.

Philanthropic qualities were assessed by measuring altruism, empathy, and compassion. Altruism was assessed with a self-reported altruism scale published by the Fetzer Institute, which consists of 20 Likert-scale questions ranging from never (0) to very often (4).[11] Empathy was assessed using the Toronto Empathy Questionnaire.[12] This questionnaire uses a 5-point Likert scale ranging from never (0) to always (4) and has 16 questions total. Compassion was assessed using the Sprecher and Fehr questionnaire, which is a 7-point Likert scale questionnaire.[13] The participant's comfort working with a population of a

Table 1. Demographics in CDAC vs. non-CDAC students

Characteristic	Student sample (n=49)	CDAC students (n=23)	Non-CDAC students (n=26)	p value
Age (years), median (range)	25 (21-31)	24 (21-31)	25 (21-29)	0.7[a]
Gender, n (%)				
Male	14 (29)	6 (26)	8 (31)	
Female	34 (69)	16 (70)	18 (69)	0.8[b]
Nonbinary	1 (2)	1 (4)	0 (0)	
Race*				
Caucasian	22 (46)	12 (52)	10 (40)	
Hispanic/Latinx	4 (8)	2 (9)	2 (8)	0.6[b]
Asian	17 (35)	6 (26)	11 (44)	
Multiracial	5 (10)	3 (13)	2 (8)	
Foreign language				
Yes	19 (39)	10 (43)	9 (35)	0.6[b]
No	31 (61)	13 (57)	17 (65)	
Medical school year				
First	4 (8)	2 (9)	2 (8)	
Second	13 (27)	5 (22)	8 (31)	0.8[b]
Third	14 (29)	8 (35)	6 (23)	
fourth	18 (37)	8 (35)	10 (38)	
Experience in a foreign country				
Yes	8 (16)	6 (26)	2 (8)	0.1[b]
No	41 (84)	17 (74)	24 (92)	
Years since experience in foreign country*, median (range)	0.50 (0.20-1.00)	0.50 (0.20-1.00)	0.65 (0.30-1.00)	0.8[a]
Years since experience since foreign country*	4 (2-7)	6 (2-7)	4 (4-4)	0.8[a]
Training in cultural competence, n (%)				
Yes	27 (55)	16 (70)	11 (42)	0.08[b]
No	22 (45)	7 (30)	15 (58)	

CDAC: Capital District Asylum Collaborative.
[a]Mann-Whitney U test; [b]Fisher's exact test.
**Missing: race (1), years of experience in a foreign country (1), years since experience in a foreign country (1).*

culture and language different than theirs was assessed using a survey with a 5-point Likert scale ranging from "not comfortable at all" to "very comfortable". The 3 qualities assessed—altruism, empathy, and compassion—along with participants' comfort with working with culturally distinct populations were deemed representative components of respondents' tendency to serve others, particularly diverse populations, and thus were quantitatively evaluated through the survey items described. Survey 1 included the items assessing altruism (items 1 – 20), empathy (items 21 – 26), and compassion (items 37 – 56) (online appendix A). Survey 2 consisted of items assessing participants' comfort with culturally diverse populations and groups who have faced racial, financial, religious, or cultural persecution (online appendix B).

Analysis

Analysis was conducted via Qualtrics and R (4.3.2, R Development Core Team, Vienna Austria). Data was summarized by median and ranges for ordinal variables and frequency and percentages for categorical data. The two-sided Mann-Whitney U test was used to compare the distribution of ordinal variables. A two-sided Fisher's exact test was used to compare proportions between groups.

Results

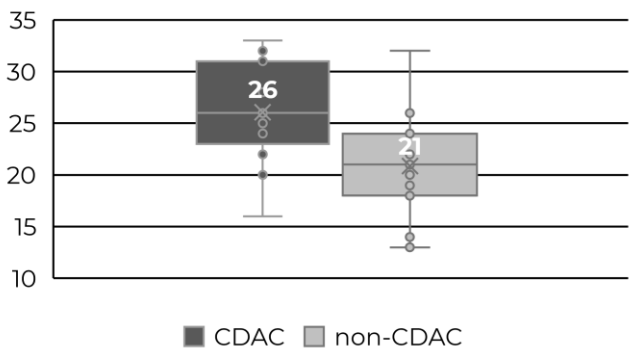
Demographics

There was no significant difference between CDAC and non-CDAC participants regarding their demographic distribution (Table 1). Age, gender, race, and year in medical training were uniformly distributed between the CDAC and non-CDAC participants. In addition, neither group had a significant difference in the amount of time spent in a foreign country or exposure to foreign experiences and languages.

Experience & Cultural Competency

CDAC participants reported a significantly greater amount of overall experience (total Experience survey score) than non-CDAC participants interacting with and servicing refugees ($p<0.01$) (Figure 1). Two of the seven experience survey statements showed differences between CDAC and non-CDAC participants which were statistically significant: "I have had plenty of experience speaking with people of a culture different from my own" ($p=0.004$) and "I have had plenty of experience listening to narratives involving significant physical and mental trauma (violence, rape, torture, persecution)" ($p=0.02$) (Figure 2). There was no significant difference between CDAC and non-CDAC participant responses regarding comfort interacting with asylum populations ($p=0.25$).

Figure 1. Level of experience in CDAC vs. non-CDAC students.



CDAC students had a higher level of experience when working with cultures other than their own and working with populations who have dealt with significant trauma as assessed with Mann-Whitney U test (p=0.01).
CDAC: Capital District Asylum Collaborative.

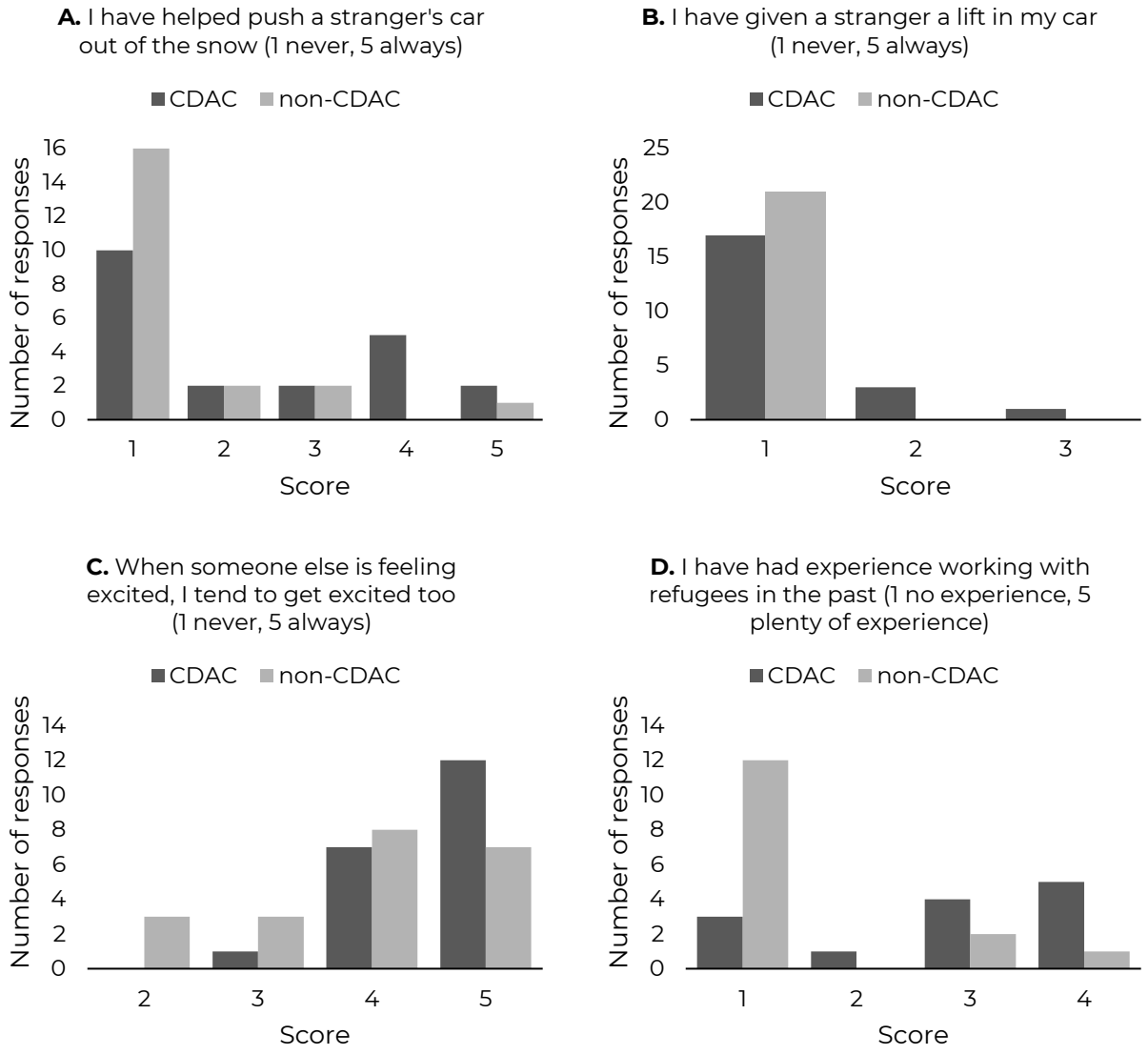
Personal Qualities Questionnaire

There were significant differences on select individual survey questions, although total survey scores did not show significance. CDAC students were more likely to volunteer for the following situations: "I have helped push a stranger's car out of the snow" ($p=0.04$) and "I have given a stranger a lift in my car" ($p=0.04$), showing increased altruism. CDAC participants also scored higher on the following empathy statement: "when someone else feels excited, I tend to feel excited too" ($p=0.03$).

Discussion

The appropriate care of all patients involves having the ability to develop communication skills that exhibit cultural competency, compassion, and a unique insight of patient emotions. This has been identified as an important skill set

Figure 2. Comparison between CDAC and non-CDAC participants in individual questions with significant differences:



CDAC: Capital District Asylum Collaborative.

in the AAMC core entrustable professional activities (EPA) guidelines as one of the ways to understand and serve the unique needs of their patients.[8] Our study sought to identify the benefits to participants of CDAC. Students gained valuable experience by listening to narratives involving sensitive topics involving physical and mental trauma, such as violence, rape, torture, and persecution. Through exposure to listening to these unique patient narratives, students also gained early training experience to develop their interpersonal and communication skills based on the AAMC published EPA guidelines. Our study also compared philanthropic qualities, including altruism, empathy, and compassion, among non-CDAC and CDAC participants. Students who participated in CDAC were more likely to report that they would act altruistically in situations where others would not.

Service-learning programs at medical colleges provide ample opportunity to expose students to communities other than their own. Gaining experience and familiarity with cultures other than one's own is vital to medical education as this

helps budding physicians into becoming more adept at caring for increasingly culturally diverse patient populations that they will undoubtedly care for during training and beyond. This also promotes an understanding on effective responses to patient emotions particularly during difficult situations.[8]

Demographics

A strength of this study was the uniform population between the experimental and control groups. Past studies have shown that empathy increases with age and is affected by culture and sex.[14] Our study's lack of statistical significance for years of training between the experimental and control groups eliminates this confounder.

CDAC participants had higher levels of cultural competence training in the past—as students and providers undergo numerous hours of intensive training workshops focused on meeting the unique needs of asylum-seekers. Surprisingly, those providers with less cultural competence training reported serving more patients of other cultures, including greater numbers of refugee or asylum seeker populations. This indicates an area of potential intervention, although it remains unclear if formal training in cultural competence would enhance the care of these patient populations. It is beneficial for patients with unique cultural backgrounds to be treated by culturally aware providers to promote an environment that aims to provide safe and inclusive patient-centered care. However, further potential benefits of formal cultural competence training should be further studied to evaluate not only the specific patient-centered, but also the population-centered benefits. Past studies have shown that most providers enjoy caring for immigrant and refugee patients.[15] However, there is still a role for programs that aim to expose students and providers to refugee and asylum populations, and groups from other marginalized populations during training and medical practice. Programs like CDAC, that are aimed to not only serve a vulnerable group of individuals, also focus on offering a unique experience for physicians and aspiring healthcare providers to enrich their professional skills. Having a longitudinal service-learning program like CDAC allows clinicians and trainees to have continuous and long-term exposure.[16] However, this training opportunity is limited to those who volunteer for the program. It may be beneficial to include some level of standardized exposure to working with refugee and asylum seeker populations for all medical students, which may further assist with EPA developments per AAMC guidelines.

Experience & Cultural Competence

CDAC students had increased comfort caring for patients of cultures other than their own and had more experience working with clients with significant trauma. There are limited opportunities in a traditional medical curriculum that provide this opportunity aside from direct exposure. CDAC participants listen to the histories of patients in unique circumstances and from distinct cultures and learn how their histories influenced their health. With this unique perspective, students develop skills to recognize how specific experiences affect patients' medical histories and develop treatment plans accordingly. Specifically, students may develop more sensitive methods of inquiring about mental health, especially when involving war and torture.[17]

Personal Quality Questionnaire

Altruism is a unique philanthropic characteristic that suggests selflessness, as there is no primary or secondary gain when participating in acts of altruism. The personal qualities survey included several notable components. The questions that were marked as most significant showed extreme altruism. For example, "I have given a stranger a lift in my car" is a rare act and may carry a higher degree of risk. Additionally, pushing a stranger's car out of the snow was more likely in those who participated in CDAC. It is highly unlikely that student CDAC participation had an effect on otherwise stable personality traits such as altruism and empathy, but rather the opposite: that students with higher levels of these very traits made them more likely to volunteer to CDAC. The lack of significant difference in total empathy and compassion scores between CDAC and non-CDAC participants may be explained by the generally high scores in empathy and compassion in members of the healthcare profession.[18]

Limitations

Limitations include the program size of CDAC, which limited our total sample size and increased the probability of type II error, especially when comparing personal qualities of CDAC and non-CDAC participants. The online survey may have limited participation but was necessary due to restrictions on in-person interactions imposed by the coronavirus disease 2019 (COVID-19) pandemic. Additionally, most student respondents tended to be first years, early in their medical career—this could potentially influence observed metrics as first year students may have differing perspectives on patient care compared to students later in education. Self-reported surveys are at higher risk of bias related to incomplete surveys, subjective interpretation of questions, and automatic clicking. Furthermore, the usage of convenience sampling also serves as a limitation and introduces selection bias; in particular, it is important to note that those who are interested and motivated to participate in CDAC may self-select because of pre-existing favorable personality traits and may be inherently more comfortable and experienced working with culturally different populations.

Future Directions

Future studies should involve the expansion of our pilot study to other programs in the New York and New Jersey areas that have asylum clinics, which would control for site-specific confounders, while also increasing the sample size to be more representative of the medical student population. Cohort and case-control rather than cross-sectional studies will be better suited to study designs to infer causality of the relationship between philanthropy and working in asylum clinics. Future studies should also address the potential effects of CDAC participation on medical student and practitioner's level of comfort interacting with marginalized and minority populations, including asylum applicants and refuges and interest levels on social justice in medicine. Another aspect of CDAC participation that could be explored is the long-term effect of working with refugee populations on the professional development and career-oriented growth of providers and students in health professions. There is limited data on downstream effects of serving refugee populations on volunteers. Thus, future studies aimed at quantifying volunteers' involvement in social justice initiatives, willingness to continue serving refugee groups, passion for teaching about refugee health, and overall patient outcomes when serving diverse populations, to name a few, may fill this existing gap in literature.

Conclusion

The CDAC has been shown to augment providers' professional and cultural growth. Exposure to asylum seekers throughout medical training increases the exposure to cultures, languages, unique experiences, and traumas in this marginalized population. It is beneficial to have providers who are aware of the non-medical determinants of health in their patients as. exercising cultural competency and identifying cultural barriers undeniably provide patients with enhanced care.

Contribution to the Literature

There is limited understanding in the literature of the specific impact that serving refugees and asylum seekers has on medical students' professional growth and experience. This pilot study lays the foundation for further work addressing the link between working with asylum seekers and refugees during medical education and providers having greater ease with tackling difficult conversations and experiencing cultures different than their own. In addition, limited studies have discussed the philanthropic qualities among students participating in such organizations. Our pilot study posits an increase in comfort and experience levels by medical students working with marginalized populations.

Disclosures

The authors have no conflicts of interest to disclose.

References

1. Westcott, SL, Badgett CJ, Stahly AV, Mader KD. Student-run clinic effect on emergency department utilization (SCEEDU): an analysis of the DAWN clinic impact in Colorado. J Health Care Poor Underserved. 2021;32(2):1069-82. https://doi.org/10.1353/hpu.2021.0081 LINK
2. Simpson SA, Long JA. Medical student-run health clinics: important contributors to patient care and medical

education. J Gen Intern Med. 2007;22(3):352-6. https://doi.org /10.1007/s11606-006-0073-4 LINK
3. Hanna K, Dasani D, Saad S, et al. Characteristics of asylum seekers in Collaborative Assessment Program. Psychiatr Q. 2021;92(3):1231-40. https://doi.org/10.1007/s11126-021-09897-9 LINK
4. Crosby SS. Primary care management of non–English-speaking refugees who have experienced trauma. JAMA. 2013;310(5):519-28. https://doi.org/10.1001/jama.2013.8788 LINK
5. Shannon PJ. Refugees' advice to physicians: how to ask about mental health. Fam Pract. 2014;31(4):462-6. https://doi.org/10.1093/fampra/cmu017 LINK
6. Lustig SL, Kureshi S, Delucchi KL, Iacopino V, Morse SC. Asylum grant rates following medical evaluations of maltreatment among political asylum applicants in the United States. J Immigr Minor Health. 2008;10(1):7-15. https://doi.org/10.1007/s10903-007-9056-8 LINK
7. O'Toole JK, Alvarado-Little W, Ledford CJW. Communication with diverse patients: addressing culture and language. Pediatr Clin North Am. 2019;66(4):791-804. https://doi.org/10.1016/j.pcl.2019.03.006 LINK
8. Obeso V, Brown D, Phillipi C, eds. Core entrustable professional activities for entering residency: toolkits for the 13 core EPAs – abridged [internet]. Washington (DC): Association of American Medical Colleges; 2017 [accessed 2022 Sep 24]; Available from: https://www.aamc.org/media/20211/download LINK
9. Bernhardt LJ, Lin S, Swegman C, et al. The refugee health partnership: a longitudinal experiential medical student curriculum in refugee/asylee health. Acad Med. 2019;94(4):544-9. https://doi.org/10.1097/ACM.0000000000002566 LINK
10. Dussán KB, Galbraith EM, Grzybowski M, et al. Effects of a refugee elective on medical student perceptions. BMC Medical Education. 2009;9(1):15. https://doi.org/10.1186/1472-6920-9-15 LINK
11. Rushton JP, Chrisjohn RD, Fekken GC. The altruistic personality and the self-report altruism scale. Personality and Individual Differences. 1981;2(4):293-302. https://doi.org/10.1016/0191-8869(81)90084-2 LINK
12. Spreng RN, McKinnon MC, Mar RA, Levine B. The Toronto Empathy Questionnaire: scale development and initial validation of a factor-analytic solution to multiple empathy measures. J Pers Assess. 2009;91(1):62-71. https://doi.org/10.1080/00223890802484381 LINK
13. Sprecher S, Fehr B. Compassionate love for close others and humanity. J Soc Pers Relat. 2005;22(5):629-51. https://doi.org/10.1177/0265407505056439 LINK
14. Quince T, Thiemann P, Benson J, Hyde S. Undergraduate medical students' empathy: current perspectives. Adv Med Educ Pract. 2016;7:443-55. https://doi.org/10.2147/AMEP.S76800 LINK
15. Alpern JD, Davey CS, Song J. Perceived barriers to success for resident physicians interested in immigrant and refugee health. BMC Med Educ. 2016;16(1):178. https://doi.org/10.1186/s12909-016-0696-z LINK
16. Levine S, Serdah M. A novel resident and medical student curriculum in refugee health. J Gen Intern Med. 2020;35(7):2237-9. https://doi.org/10.1007/s11606-020-05693-6 LINK
17. Griswold KS. Refugee health and medical student training. Fam Med. 2003 Oct;35(9):649-54. https://pubmed.ncbi.nlm.nih.gov/14523663/ LINK
18. Krishnasamy C, Ong SY, Loo ME, Thistlethwaite J. How does medical education affect empathy and compassion in medical students? A meta-ethnography: BEME guide no. 57. Med Teach. 2019;41(11):1220-31. https://doi.org/10.1080/0142159X.2019.1630731 LINK