TranscribeMe!

Transcription details:

Date:	01-May-2023
Input sound file:	CPSolvers ARM Episode 21 Audio.mp3

Transcription results:

Sud Krishnamurthy: 00:20	[music] Hi everyone, this is Sud Krishnamurthy. Welcome back to another episode of the Anti-racism in Medicine Series of the Clinical Problem Solvers podcast. As always, our goal on this podcast is to equip our listeners at all levels of training with the consciousness and tools to practice Anti-Racism in their health professions careers. I'm thrilled to be hosting this episode today with Lash and Ashley. On today's episode, we'll be discussing some of the challenges associated with resettlement, psychosocial, and cultural considerations for providing healthcare to immigrant and refugee populations. I'm really excited to have this discussion with our guests, Dr. Altaf Saadi and Dr. Naweed Hayat. Lash and Ashley, I'll hand it over to you to introduce our guests today.
Lash Nolen: 01:07	Thanks so much, Sud. I'm also very much so looking forward to our conversation. And first, I'm going to introduce Dr. Naweed Hayat. He's currently a child and adolescent psychiatry fellow at the University of California, San Diego. Dr. Hayat completed his undergraduate education at UCLA in neuroscience, followed by medical school at the University of Arizona, COM, in Tucson, Arizona. He trained in Texas Rio Grande Valley, at the US-Mexico border of Brownsville, McAllen, where most families were separated from their parents, where he has trained to conduct asylum evaluations and support migrants in the community. Dr. Hayat grew up in Afghanistan during the civil war of the 1990s and is a refugee with the lived experience of resettlement himself. His interests lie in the effects of war, conflict, and migrations on mental health from a biopsychosocial cultural perspective, and he works as a physician in mental health with adults, children, and adolescents from various backgrounds, including the refugee population, both in formal and informal settings. Thank you so much for joining us, Dr. Hayat.
Dr. Naweed Hayat: 02:18	Thank you.
Ashley Cooper: 02:20	Thank you, Lash and Sud. And now I'm going to introduce Dr. Altaf Saadi. Dr. Saadi is a general neurologist at MGH and assistant professor of neurology at Harvard Medical School. She's also the associate director of the MGH asylum clinic. Her federally funded research focuses on neuropsychiatric health disparities and addressing the needs of displaced populations, both within the community and immigration detention. She was named a 2020 STAT Wunderkind, 2021 National Minority Quality Forum 40 Under 40 Leader in Minority Health, and received the 2021 YW Boston Academy of Women Achievers Sylvia-Ferrell Jones Award for a rising professional woman of color, who's a leader in her field and changing the city of Boston. She's a graduate of Yale College and Harvard Medical School, completed her neurology residency training at the Harvard Mass General Brigham Neurology Program, where she also served as chief resident, and completed a health services postdoctoral

research fellowship with the UCLA National Clinician Scholars Program, where she also earned her master's in health policy management. Welcome, Dr. Saadi.

Dr. Altaf Saadi: 03:23 Thanks so much. I'm excited to be here.

SK: 03:26 Thank you both so much for joining us today. I know I speak for all three of us and all of our listeners when I say that we're really excited to have this conversation with the two of you. So with introductions, with that, let's jump right into it. As highlighted by our introductions of you, both of you do such important work. Dr. Saadi, you've written about how you grew up during the aftermath of the war in Iran. And Dr. Hayat, you've generously shared that you've lived during the Afghan civil war and are a refugee from Afghanistan yourself. I was wondering if both of you might be willing to share your own stories that have inspired the work that you do today.

S5: 04:04 Naweed, I'll let you take this one first.

NH: 04:06 All right. Not a problem. Thank you, Dr. Saadi, and it is a pleasure to be here. So yeah, I mean, a little background on geographies. You all may know where Afghanistan is. It's a small country, the size of Texas, in a central South Asian area. And there have been five major waves of migration in the last 50 years, I would say, initially with the Soviet-Afghan War, and then displaced around 2 to 3 million people, and then the Afghan Civil War, which I grew up in, and then the fall of the Taliban. And then, as you may recall, in August of 2021, which the US and Western forces left. And that was another major wave of migration from that part of the world. My personal experience in the '90s was right after the collapse of the government at that time, and I was very little. So after that, much later was a lot of street fights within Kabul, and a lot of people lost their lives. And people kind of went back to that basic Maslow's hierarchy, looking for food, shelter, water, and safety. And a significant amount of them left and went to Pakistan as refugees, and significant amount to Iran and to other parts of the world. Yeah. So that was the component of my background. I'll let Dr. Saadi talk about hers.

AS: 05:49 So my experiences are less direct, but my parents left Iraq when it was under Saddam Hussein's dictatorship. So he was a dictator who targeted thousands of Iraqis who had Iranian ancestry and also Shia Muslims, so including members of my family. I, myself, was born in Iran, and then we immigrated to Canada and then to the United States. And our immigration to the US happened a month before 911. So after which a lot of Muslim Americans, but also, South Asian Americans, Sikh Americans, Arab Americans who were not Muslim, were also targeted. So and I remember having a friend in high school who had, sand and then the N word sprayed on his driveway, or myself being called the raghead and yelled other things. I think I have to say that, certainly, I think a lot of my personal experiences and those of my family more broadly really do inspire the work that I do. And I also just wanted to mention that, like Naweed, I also conduct medical and psychological forensic evaluations for people's applications for asylum and other forms of humanitarian relief, just that each evaluation is also a driving force. So it really is so much more than just my personal stories. And I think seeing the commonalities in people's experiences who are subject to whether it's human rights violations or war or civil conflict or sort of these larger global factors that really devastate people's lives.

LN: 07:32 Yeah. Well, thank you both for sharing your personal experiences, and we really appreciate you all taking the space to share that with us. My next question is about the state of the border currently. And for many who resettle on the United States,

their first interaction with the country is the border, which is especially relevant considering recent immigration policy from the Biden administration, such as lifting Title 42 and other policies that some have likened to Trump era immigration policies. Dr. Saddi, you've written about the need for more humane border policies and dismantling migrant protection protocol, or MPP. And I'm interested if both of you would tell us a bit more about the current state of the border and a little bit about the psychological and the physiological impacts of the violent experience at the border and how you take that into account when you're caring for your patients.

AS: 08:30

So I can start. I will say that, first, before I answer that question, I do want to push back a little bit against sort of a narrative that I think oftentimes is really hyper-focused on the US-Mexico border. So in a lot of talks that I give, I always make sure to mention that the majority of immigrants don't come through the border, even for people who are undocumented. More people who are undocumented are so as a result of overstaying a visa, meaning they came here on a valid visa rather than coming through the border. So I think that's important to mention because I do feel that oftentimes there is a hyper-focus on the southern border and, as a result, increased surveillance of people who are going through there. So I just wanted to mention that, although there certainly is a lot happening at the US-Mexico border. And Naweed, you practiced there, so you'll have a lot to say about that.

AS: 09:30

But I'll just mention that, oftentimes, what happens through a lot of policies that happened under the Trump administration, but even now that are being proposed by the Biden administration, really leave people vulnerable in Mexico and other countries in Central America. That subjects them to whether it's sexual or other violent assaults. They're living in makeshift encampments. They don't have access to adequate food, water, and shelter. And we're recording this podcast right now, right at the heels of the news of a detention center in the Mexican border city that burned down and led to 38 people dead and others who were seriously injured. So what we're talking about is people who're fleeing persecution, gang violence, other violence that they're worried could cost them their lives. And they're being met with conditions, whether it's at the border or on route to the border that are also degrading their humanity and are also subjecting them to conditions that could cost them their lives, and I think that's a really important part of the story.

NH: 10:47

Yeah, so my first exposure at the border was at the border called Torkham. It's between Afghanistan and Pakistan. That was my first exposure as a child. And what I remember is exactly what Dr. Saadi was referring to. It's chaos—just a lot of confusion—with people trying to go from one side to the other to figure out what the next step is. What's the unknown? So a lot of trauma that occurs in that particular physical space, leading to potential mental health consequences later on in individual and families. And border in that sense has been special in my life. Yeah, and that was my first exposure. And then when we moved to the US, to Dr. Saadi's point, sometimes we don't hear about a lot of immigration that occurs in other parts of the world, right? And the things that we can learn from there. Originally, we moved to California, where we're closer to the San Diego- or Tijuana-California border, then my med school in Tucson, Arizona-Mexico border, in Rio Grande Valley.

NH: 12:05

So I've always been close to the border all my life. And in some ways, it's a special distinction between how we are separated being equally human on both sides and in terms of our rights and what we qualify for, what we don't qualify, how we get treated. So those were kind of the main things that I would highlight from my experience at the border. And currently, at the US-San Diego or Texas-Mexico border, a

lot was going on when I was in residency as well. We, unfortunately, did not go to the side of the border to meet with families, but I had the honor of working with families who were refugees and kind of the aftermath of when they resettled and the traumas they went through. In terms of the government policies, I do not have a lot of information on that. So Dr. Saadi highlight those, but those are my thoughts on it.

AS: 13:15

I'll piggyback off of that. I think to say that, oftentimes, when we think about refugees or immigrants, we often think about sort of their conditions in their home countries, and then once they come into the country or the US, we think about it as sort of the simple pre-post. But I think, to Naweed's point, that it really is a journey we have to think about, whether it's people who go from camp to camp to camp or who might go from camp to living in one city, then they live in another city in a different country. Oftentimes, there are so many points before they end up in the post-migration aspect of the continuum of experiences. And I think that's really important to keep in mind when we talk to patients who are immigrants or forcibly displaced, and really not thinking of it as this clear pre-post distinction but really a journey that can include whether it's being in an encampment or whether having been detained in immigration prison, whether it's having multiple countries where they might have stopped on the way to their final destination. I think Naweed's sort story and his experience sort of highlight that.

AS: 14:44

And then the other point that I think is important to mention also is that I think what often gets left out-- again, the focus is on people that we end up seeing in clinic, but I always try to mention that there are so many people that we're not seeing who might have drowned or died at the border. We know that, in 2021 and 2022, these were the deadliest years in the past decade for migrants crossing the US-Mexico border. And last year, I think what was recorded, which we know is probably under-recording since so many people are lost and people are just not kind of tracking it or recording it-- but just last year, at least 853 migrants died attempting to cross the border. And the Missing Migrants Project is an online resource that tracks deaths across the world. So I think thinking about that. So I know that doesn't answer the question directly, but I just think it's always important to think about that and how this is such a more expansive issue than just the people that we might have the fortune of seeing in clinic.

AS: 15:58

And then the other point that I will make to answer your question about things that we think about - Naweed is a psychiatrist - is thinking about the higher prevalence of mental health challenges. I'm a neurologist, so I have an interest in traumatic brain injury. So thinking about physical-based injury alongside psychological injury that can occur and how they can be mutually exacerbating, people who might have interruptions in their care - like, let's say, they have hypertension and then their care is interrupted - And then also thinking about community-level trauma. So then once people come and then they resettle, they're subject to whether it's anti-immigrant attacks or xenophobia. And so it's really a compounding trauma that occurs sort of across the continuum of their experiences post the migration journey, but then also at different levels, so psychologically, physically, and then at the community level.

AC: 16:59

Thank you both so much for your responses to that question. And Dr. Saadi, you talked really specifically about this, thinking about the compounding trauma that occurs for these populations. And as we know, there's a great deal of trauma and violence associated with resettlement for refugee and immigrant populations. So given this, I wanted to ask you both to share a bit more about your perspectives on the

importance of providing culturally competent and trauma-informed care and how you approach this in your daily practice.

NH: 17:26 I can go first.

AS: 17:27 Yes.

NH: 17:30 Or wait, Dr. Saadi, you want to go first? [inaudible]. But yeah, to your point, Ashley, culturally competent, as Sud was sharing in the introduction about my interest in cultural psychiatry, it really makes a big difference along with that biopsychosocial model and building rapport. To what Dr. Saadi was saying earlier, there's the pre-2000 model of looking at mental health in refugees as war, conflict exposure, home country, the US, or wherever they may be where they're getting evaluated. But there's a lot that goes on in between, and to be sensitive of that too, being that those things may have happened, including discrimination, physical abuse, emotional abuse, vulnerability, hunger, all sorts of things that they may have gone through. Just acknowledging it, I usually tell them, "If I tell you that I feel you or I understand or-- I would be lying, because I don't. But I do want to empathize at a human level that you have suffered and you've been through a lot. And I appreciate you being here and sharing this with me."

NH: 18:51 And a big part of that culturally competent or culturally sensitive model is also making sure-- a lot goes on. There's language barrier. There's cultural barrier. Ideally, you would utilize somebody who's both fluent in language and who has some awareness of the cultural sensitivities as well and the cultural values to that person. And being curious, I think DSM did a good job of creating a cultural formulation in DSM-5 and the one afterwards. Just being curious, learning about them, how do you define these things that you're experiencing? What does your culture say about it? Tell me your thoughts before we share our Western model or what we do, based on evidence, that we do on day-to-day basis.

AS: 19:41 Well, thanks so much for that, Naweed. I really like the cultural formulation interviews that are offered to the DSM. I think they're great. I think I wanted to address sort of two aspects of trauma-informed care that I think often gets neglected. I think a lot of the focus is-- and yes, you should do sort of the interpersonal things, like screening for trauma exposure, providing resources to families, making sure there are appropriate language services, normalizing trauma that might happen at the border, all these experiences. But I think trauma-informed care should also happen at an organization level. So I just wanted to talk about that briefly because I think, oftentimes, we forget about that or we let healthcare organizations sort of off the hook when we're just talking about individual interactions. And I have done some work looking at what healthcare organizations can do to create sanctuary or immigrant-friendly spaces and sort of propose the idea of immigration-informed care, which is sort of built on the concept of trauma-informed care, to think about unique factors that we need to think about for immigrant populations.de

AS: 21:34 So there's all these factors or things to think about that are at the organizational level that I think contribute and I think should be part of our conversation about trauma-informed care for immigrant populations, but really for all populations. And then the other element, I think, of trauma-informed care that I think that is under-discussed is the idea that people aren't the sum of their traumas, that there's so much more to individuals, especially immigrants, especially forcibly displaced people. They're not just their trauma experiences. They're not just their immigration

status. And I think this is something that I am especially sensitive to, I think, especially given my family background. And seeing, oftentimes, this narrative that reduces people to just this trauma exposure that they've had is actually, I think, one of the reasons why, when you interview a lot of refugees, sometimes people really actually don't even like that term because it's like, "Okay. Well, maybe I was a refugee, but that was then. And I'm so much more than this label that gets attached." And so I think that is also an important part of trauma-informed care. It's not reducing people to their traumas and appreciating people as more than just the trauma exposures that they've had.

SK: 23:04

I think that's such a good point. We, especially in medicine, tend to reduce people to these one-word labels very often. And the use of language is such an important discussion, and I wish we had more time just to discuss just the use of language around this topic. But I want to circle back to something that you had brought up a little earlier, Dr. Saadi. You had talked about creating sanctuaries in these hospitals that are meant to be healing spaces. And you have written about why we should keep ICE, or Immigrations and Customs Enforcement, officers out of the hospital. In Episode 16 of our podcast series, we've discussed the use of security within hospitals to disproportionately police black patient compared to white patients. And Dr. Saadi, you've also written about the danger in the use of chokeholds in policing. I'm wondering if you could both tell us, or tell us and our listeners, a little bit about the policing of immigrants and refugees and explain why it's critical that we keep these bodies of policing, like ICE and the police departments, out of healthcare settings.

AS: 24:22

Yeah. Thank you for that question. So cases of immigration enforcement in healthcare settings are rare, but they have happened. There are instances of patients being questioned or interrogated at the bedside, people being arrested as they step out of the hospital when they went to visit someone. And all this sort of contributes to fear that really dissuades people from seeking care they need. And there are some even more egregious examples, so I'll give you an example in Highland Hospital in Oakland. So this was in 2014, where they actually installed a surveillance camera at the entrance of the emergency department, and it automatically read license plates of all cars coming into the emergency department, and then they sent those numbers to a database that law enforcement agencies, including ICE, could access. So I've been collecting stories like that for years now. And again, they are rare. But they scare people, and they contribute to fear that extends far beyond just that one institution or just that one local area, that one instance. And it's fear that persists for years.

AS: 25:39

In interviews I did for a project around sort of these healthcare organizational practices, someone I interviewed referred to fear-- they said something like, "Fear spreads like TB." And I like that analogy because I think, especially for us in the medical profession, it helps us understand how again it really is more than just one person who might be scared or one person who might have heard about something. It really spreads within communities. And I think that's why we need to make sure there are these healthcare-organizational-level policies and practices in place because, when people delay care-- this is sort of what we know now. We've seen over and over again in every population that's marginalized, people delaying care leads to worse health issues right down the line, and that's harmful to them in the long term. That's more costly to the system in the long term. So it's really important to think about and not dismiss as just, "Oh, this was a one-off thing that happened," because it has happened enough times, even though it's rare. But it has really instilled fear in communities and distrust of potential collaboration between healthcare organizations,

or public health organizations, and healthcare systems. So we really need to be proactive rather than reactive about it.

NH: 27:22

Yeah. Dr. Saadi, some of you have done some fantastic work in this area. Thank you for sharing that. To your point earlier about system-level of advocacy and system-level's change. Not just with refugees or immigration, I work with kids here daily in child lesson unit, and I work with parents most of the time. And its system sometimes feels so fragmented that one part does not talk with the other, and sometimes healthcare providers are placed in that middle to kind of navigate like, "Okay, this is going to be the next step. This is where we are right now." Areas where we can-- I think there's a large area for improvement to create more bridges between services, between different organizations to streamline the process, which I think will likely result in some decrease in the trauma that's associated just with the organizational component of it, like, "I didn't know where I was going to go next, what's going to happen." And along with that also I think what will be beneficial is that some places have done a great job of that, is creating a relationship with the law enforcement, educating them, learning about their challenges for them to learn about our challenges, and realizing our common goal of what is it that we're trying to do and how we can do it best. So things like we're doing right now, having a discussion about it, really helps us to explore areas where chain needs to happen.

AC: 29:02

Absolutely. Thank you both so much. And I wanted to ask about the impact of health records on providing care to refugee and immigrant populations, because the lack of access to universalized medical records can often lead to poor quality healthcare outcomes and lack of continuity of care, as we've talked about a bit earlier in the podcast. And this fragmented care also leads to the lack of reliable data for policymakers to allocate health services for these populations. So I wanted to ask how you both have dealt with this in your practice, and if you could share your thoughts on potential solutions to this issue.

AS: 29:34

I can start. I think this is challenging because I actually think immigration status is a little different from other social determinants of health in that I don't think it should be documented explicitly in health records because it can subject people to harms, so whether that's through stigma from providers - and I think this goes back to your point earlier about language that we use - or potentially, harms of medical records have to be turned over to law enforcement agencies, who may cooperate with immigration enforcement. Again, there haven't been cases of that, but because of that potential harm, a lot of legal organizations do recommend against documenting immigration status in medical records. And we have an article published in the American Medical Association Journal of Ethics around not documenting in medical records. That doesn't mean that the needs of this population can be met. And I think this is where the partnerships with community organizations are going to be really helpful in terms of attending to people's needs. But yeah, I do think that this is a little tricky, I think, given particularly the state-- politics under the Trump administration. Those fears around what happens with data that we collect in an administration that wanted to create a Muslim registry. It's really scary when we think about, "Yes, we can collect this data," but how are we ensuring that this data is protected? Who is it being shared with? So there's all this groundwork and thought that needs to be put into that and protections around that before we move forward with, "Okay, let's collect this information."

NH: 31:28

Yeah. Actually, you asked the billion-dollar question about EMRs, or electronic health record systems, in general. I mean, even not dealing with immigration, in general population, we deal with this: the harm that can be done with discontinuity of care,

lack of records between providers. And specifically, in our field, that-- I can apply it to Dr. Saadi's point about, "What goes into the health record?" What goes into that note? Specifically, if I have to say, with psychotherapy, we have our process note, where we keep details of intimate things that may be coming up in that conversation, and then we have our record note that goes into the record. So the basic reasoning behind it is, "If I put a line there, what is it going to do for this person? Can it be used to help, and can it be used-- a future provider could provide them assistance. Can it be used to harm this person?" So you always juggle with those decisions before you put something because it is a permanent record and could be pulled out anywhere for any reason. And then you have to be able to defend that, why you put it there, and deal possibly with the emotional consequences of it if it ends up harming somebody, like, "Did I really need it there?" So that's a great question, and I think, again, dialogues need to continue until we find that optimal system that will work best.

AS: 33:04

I'll add one more thing, I think, to Naweed's point, which is around that this is really permanent record. So immigration status changes. It changes. People are people. Let's say, even if they're undocumented, if they can apply for asylum, then they can become citizens. But then something could be in someone's chart and it stays there forever, and people can make incorrect assumptions about them and say, "Oh look, this person; it says here that they were undocumented. They don't qualify for services," or "They're not going to be able to apply for this thing." But that could be inaccurate. That could have changed. And so, I think this is probably a larger conversation for another podcast if you guys haven't done it already, but around medical records and how we sometimes can perpetuate harms through them. But yeah, that's something I think about a lot.

AC: 34:02

100%. 100%. We agree. It absolutely could be a whole nother podcast conversation in itself. And I think what you both are bringing up is just how sacred the relationship is between a patient and their physician and how much trust is needed to make sure that that space remains safe. And I think that, through the electronic medical record, the way that we're having conversations about how we treat our patients who are immigrants, it's just so critical to make sure that that space remains healing. And I just really speak on behalf of the team when I say thank you all so much for providing this incredible insight because I think that our listeners are going to walk away with so much to really chew on and to provide the best level of care for these patients. So as we wrap up, I just want to end on the note of, "What can we do with all of this wisdom that y'all have shared with us today?" So our final question is for our clinicians and trainees who are listening, who will step back into the clinic or hospital tomorrow to care for patients. Could you both share how our listeners might apply the teachings from this episode into their practice? And since so much of our conversation also centered around contemporary policy as well, do you all know of any ways that folks can maybe engage in advocacy, either at the local, state, or federal level, to really push back against some of these policies that could be harming some of our patients?

AS: 35:31

I appreciate that question because I'm going to self-promote some of my work. [laughter] So the research produced a toolkit around policies and actions that can be implemented at an organizational level. That is publicly available at doctorsforimmigrants.com. And you can look at-- there's sort of a tab that'll say The Toolkit, and there's videos that break those down. But there's so many more organizational-level policies and actions that can take place beyond ones that we've already talked about, so like setting up a medical-legal partnership where people can connect to attorneys that can help them with their immigration case or civic

engagement, promoting that, getting people to vote, so naturalized citizens who may be new to voting. There are a lot of efforts around that. So check out our toolkit on doctorsforimmigrants.com. I also want to shout out a friend and bioethicist at Loyola University Chicago Stritch School of Medicine, Mark Kuczewski, who has a sanctuary doctoring toolkit. So recommend. You can just Google that. And his toolkit really focuses much more on the individual level. So those are two concrete toolkits that you can look up and read about. And then I will say that I'm not a big fan of reinventing the wheel, so it really is "Amplify good work that's been done." So I would encourage people to build partnerships with local organizations who are uplifting these communities. So wherever you are, I'm certain people are already doing this work and working on these issues, so seek them out. See what is already being done, and again, in terms of what you can do.

NH: 37:23

I agree 100% with all the points that Dr. Saadi brought in. There's also a group-- shout out to Olivia [Sade's?] group in New Mexico. They have a workshop on doing mental health evaluation, if anybody's interested, for asylum seekers. But just to see, what are the goods of the system that currently exist? And what are the areas that need to change? And finding really the stakeholders. It may be through the local political office or just researching great report that Dr. Saadi has been doing. And I think, for us in the mental health field, that ongoing advocacy is also addressing fear, the stigma associated with seeking help, and providing psychoeducation. And sometimes I find or we find ourselves to be this bridge between the patient and the outside world and kind of sharing the challenges to both sides. And also, two other things I wanted to share, going back to what Dr. Saadi said earlier, that the person is more than the label that we're forced to put-- their chart, right? Like major depressive disorder or PTSD, post-traumatic stress disorder. I share with my patient like, "You're not a disorder. These are set of symptoms that can be treated. You're much bigger than that. And then our role-- let's say, you're in the driver's seat; our role just supplement yours to see how we can help so that you can do the greater things that you've always wished to do."

NH: 38:59

And the last point would be also for healthcare providers in general to be aware of our own limitations. My residency training was pretty heavy in psychodynamics. So one of the terms that I use frequently is that Rescue Fantasy: to not fall into that trap and take too much than we can handle, where it may affect us and our lives. So I've trained my mind, for example, when I leave the hospital, to try my best to leave everything in the parking lot and don't take it home with me, and understand that I do what I can and there are things that I may not be able to change in my lifetime, but I'll do that small part that I can, and hopefully, that'll add to the bigger goal and bigger picture.

SK: 39:54

Thank you both so much for joining us today. We have covered a wide range of topics, starting kind of from the traumas associated with resettlement to police and immigration enforcement, language we use in medicine and the stigmas associated with it, and then all the way to kind of what we document in our charts and the harms we perpetuate with what we do put in there. And I know I speak on behalf of our team and all the listeners today, that we're so thankful that you both agreed to join us and educate us. I hope you all have a great rest of your days, your weeks, and continue to do the important work that you're doing. [music]