HOME & ABROAD

THE MIGRATION EDITION

23'-24'

FROM THE EDITORS

To our readers both in and outside the UTSW community,

We are extremely pleased to announce the 2024-25 edition of Home & Abroad, UTSW's annual global health publication. Featuring a mosaic of artistic expressions pertaining to relevant global-health issues in today's society, this issue is an amalgamation of personal narratives, poetry, paintings, and real-life interviews from like-minded medical students and professionals who are passionate to raise awareness in promoting health equity and justice globally.

After multiple rounds of editing, organization, and collaboration, this version is both an authentic and reviewed expression of global health challenges that we must acknowledge and overcome, from medical students here at UTSW. We are so proud of all the incredible contributors to this work, who have poured their heart and soul into every piece that is presented before you.

Wait no longer, and turn (or scroll) to the next page to start reading!

Sincerely,
Mayuri, Sofia, Benjamin, and Koshma
Home & Abroad 2024-25

Disclaimer: Home & Abroad is published by the Home & Abroad magazine staff, a registered student organization. Home & Abroad is not an official publication of UT Southwestern and does not represent the views of the university or its officers.

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The Tanoura, by Jana Kholy

The tanoura, a whirling dancer symbolizing the rotation of the Earth around the Sun, has been adapted from 13th-century Sufism to present-day Egyptian culture as a celebratory practice.

The folk dance's colorful dynamic skirt, illustrated here in oil pastel, epitomizes centuries of cultural flow across the SWANA region.

This cultural flow continues today across national boundaries, with my parent's own migration, bringing a piece of the ancient practice to the Egyptian diaspora in none other than Dallas, Texas.

Jana is a 4th year medical student planning to pursue a career in internal medicine.

Outside of school, she enjoys painting, archival fashion, and spending time with her pup.

The Gain of One Home at the Cost of Another

BY ANISH GOEL

Spending only the first 6 years of my life in Singapore and being one of few Indian kids in my hometown of Cypress, Texas, I never felt very connected to my own culture. Perhaps this stemmed from moving to America when I was still young, or perhaps this was just the lack of the Indian community in the area that I moved to, but I did not consider being Indian or South Asian as a major part of my identity growing up. This certainly allowed me to assimilate into American culture; however, in the process, I was unable to engage with my own culture. While moving to a new place is associated with the difficulty of assimilation, it also places barriers in participating in one's own culture.

I had not built an understanding of who I was within my own culture at the age of six. When my environment changed, so did I. While the move was happening, my parents encouraged me to participate more in American culture and less on our own. I was living the 'American dream' most immigrant parents wished for their children: to grow up in America, assimilate within the culture, and pursue the opportunities they worked so hard to provide for me. This worked. I was able to "fit in", I spoke great English, and I understood pop culture references made in conversation.

Nevertheless, upon returning to Asia, I felt lost. My older sister spent 7 more years living in Asia than I did, and had mastered our native tongue, Hindi. By contrast, I struggled to parse the speech. I knew very little of the grand celebrations of Holi and Diwali, which my parents would recount.

The walls I built between me and my culture were not only created entirely by myself and my family, but also by the introduction of systemic factors. I went to school and learned about how the Mediterranean diet is 'the healthy diet'. When my doctor gave us information about nutrition, they recommended foods we had never heard of before. Like many immigrant children, I shared the experience of bringing my mom's home cooked food to the lunch table and having it be described as 'gross' and 'smelly'. Afterwards, I often avoided bringing Indian food to school and further distanced myself from my own background. As a result, I never felt truly connected to my own culture, religion, and people. The conversation around migration is often centered around how immigrants adapt to their new home. However, an issue that is not often spoken about is how easily young children of immigrant families fall out of touch with their cultures. More recently, people have been moving around the globe for a variety of reasons. This will lead to a larger number of children who grow up disconnected from their backgrounds.

However, it does not have to be this way.

As future and current medical professionals, we can do our part to prevent this. We can have models for health that are more flexible to account for cultural variations. Instead of recommending specific meals, we can utilize tools such as macronutrients or categories of foods. By spending more time with our patients to better understand them and their needs, wants, and abilities, we can create a model for health that does not impose undesired cultural imperialism.

Our recommendations and conversations should not be a script read out to every patient that walks into the clinic. People are infinitely unique, with variation in every aspect of their being. If we fail to recognize this, we will fail to create individualized care that properly accommodates our patients. We, as the people privileged to be learning about health, should use our privilege with greater awareness than a generalized handout.

As the global population centers change in both location and density, we must take care to remember that our unique backgrounds are something to be celebrated. In healthcare, this means understanding non-Western models of health and realizing the wide range of values that people hold surrounding health. Just as importantly, as individuals we can keep ourselves open to new experiences and constantly strive to keep learning. Though these tasks may seem daunting, I am certain that through understanding the true impact our words and actions have,checking our biases for a more flexible and accommodating worldview, and recognizing the value in diversity, we can help create a world where we can connect with our heritage and our local community.

1. https://www.pewresearch.org/short-reads/2022/12/16/key-facts-about-recent-trends-in-global-migration/

Anish Goel is a second-year medical student at UT Southwestern. He was born in Singapore, and he spent most of his life growing up in Texas. His hobbies include reading, lifting weights, and brewing mead.

BY KACIE SHANNON

In the Spirit of Hospitality:

REFLECTIONS FROM CASA JUAN DIEGO

Sitting across from "Maria" in the patient intake room at a free clinic in Dallas, I noticed the complexity of emotions adorning her eyes. Maria recounted the story of her family's immigration from Romania nearly 60 years prior. Her expression and intonation made evident the struggle and hardship of adjusting to a new life, adapting to a foreign culture, losing family members, and depending upon the kindness of strangers and her church to make ends meet. Nearing 90 years old, this kind-hearted woman carries with her a lifetime of wisdom and experience, along with a steadfast faith that has continually empowered her to surrender and trust in the promise of a new life. Her witness to hope was beautifully reminiscent of the countless narratives I encountered while living at Casa Juan Diego, a Catholic Worker House in Houston that serves as a space of hospitality, respite, and provision for migrants on the long journey in hope of a new life.

I was inspired by the Catholic Worker Movement's founding principles of social justice, personalism, and nonviolence. I found myself eager to see how this philosophy informed a compassionate response to the migration crisis. While many classifications describe the reasoning for displacement, such as 'migrants,' 'refugees,' or 'asylum seekers,' only two descriptors truly matter at Casa Juan Diego: brothers and sisters. At Casa, the emphasis is never on legal or social status. Instead, the focus is on the reality that numerous people are fleeing desperate situations and have journeyed thousands of miles while encountering kidnappings, robbery, rape, and even death. They arrive urgently in need of safe and dignifying care in a foreign land. Casa Juan Diego, an outpost of compassion along this grueling trek, humbly meets this need by offering shelter, a food pantry, clothing, a health and dental clinic, and various social services to the migrants.

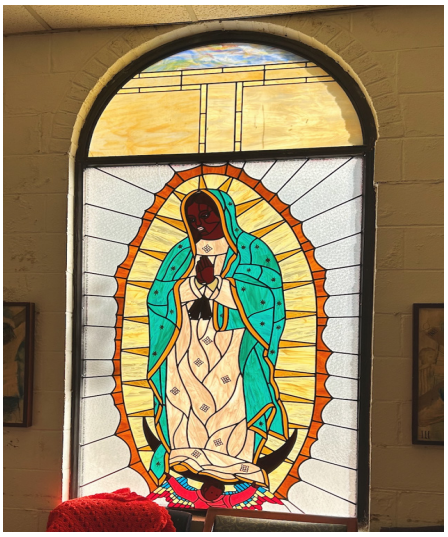
When I started my journey as a Catholic Worker, the eclectic happenings of Casa Juan Diego overwhelmed me: pallets of produce and canned goods lining the hallways, volunteers intently beelining in every direction, an extensive line of sick and injured people patiently waiting outside the main door for their monthly assistance, and a steady stream of people coming for bags of food. The most salient sight was of weary new immigrants approaching in search of safe shelter during their first days in the country, often bearing few physical belongings but cumbersome emotional baggage.

With time, each moving part of Casa began to disclose its identity. The pallets of food became a source of sustenance for hundreds of families. The band of volunteers were instrumental in transporting children to receive vaccines, driving pregnant guests to their prenatal appointments, and collecting dozens of prescriptions to help the clinic patients live with dignity by more comfortably managing their illnesses. The influx of donated sandwiches was nourishment for the male guests who left the house each day in search of work, the women who waited in-line all day at the Immigration Office, and the folks living on the streets who were regularly welcomed at the door. The bags of 'masa,' which had previously been foreign to me, became a staple ingredient of arepas, a tasty dish that our beloved Venezuelan guests cooked for the household with passion and pride. The long line outside the door transformed from a purely daunting sight into an opportunity to personally greet each visitor, hear their story, and respond with simple but purposeful actions.

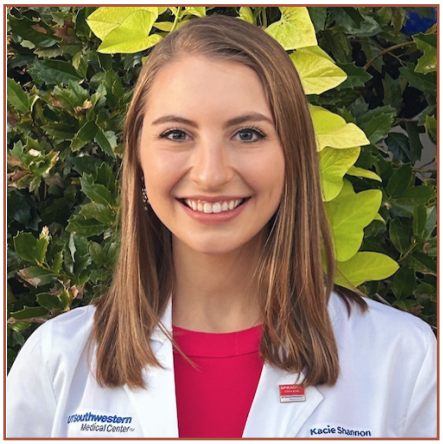
Our guests were blessings from whom I learned countless lessons, especially in the realm of hospitality. "Laura," one of our longer-term guests at the women's house, acted as a maternal figure for our newer, unsettled guests. I recall a migrant who was particularly troubled, fearful, and on the verge of tears. Sensing her discomfort, Laura took the new guest under her wing and directed her to get a meal, coffee, and a chair to rest. She then sat with the woman, held her hand, and attended to her. This was only one occasion of many in which Laura helped love someone into a better existence. A month prior, another guest had slipped and fallen down the stairs, whacking her elbow on the tumble downward. All the women of the house flocked to her side and began tending to her, and Laura immediately volunteered to accompany the injured guest and stay with her in the ER – an ordeal that could have lasted all night. I continually admired that our house of hospitality lived up to its name predominantly because of the patient, kind, and nurturing guests who inhabited it.

Living in devoted service and community with some of the most vulnerable, vilified, and outcast people was the gift of a lifetime. Among many discoveries at Casa, I affirmed that no linguistic, cultural, or socioeconomic barriers can hinder the formation of cherished relationships. This awareness coincided with my intensified eagerness to meet people where they are, which is often within a complicated and distressing situation, and to love them all the same. A necessary clarification is that this is no easy love. Truthfully, every day was a test of patience and strength. The daily and nightly work at Casa was an exercise best summarized by novelist Fyodor Dostoevsky's words, "Love in action is a harsh and dreadful thing compared to love in dreams." I recall a particular instance that demonstrated this idea. One night, I heard an urgent knock on my door from a guest who had been worried sick about her husband being stuck in a detention center. As I often did in those moments, I uttered a quick prayer for strength and proceeded to open the door. The guest thrust over her phone and pointed me to talk to a taxi driver who was inquiring about what to do with the phone-less, fund-less, Portuguese-speaking husband who he had just picked up from a detention center in California. The four of us – the woman, her husband, the taxi driver, and myself – went back and forth over the phone for quite some time, nearly waking up the entire household as we frantically created a plan to aid this new migrant to safety. The next morning, coordination by volunteers helped ensure the safe passage of the guest's husband all the way to Casa Juan Diego. While situations are seldom easy when aiming to meet others where they are, I always remind myself that God, too, will meet us where we are – in feelings of impatience, inadequacy, and insignificance – and help us to persevere. It is the difficult love in action, such as the compelling nighttime conversations that span multiple linguistic and social barriers, that draws us closer to one another. Close enough to experience the joy and suffering of our fellow brothers and sisters, and close enough to appreciate our common humanity.

I could never have imagined discussing life stories, sharing laughter, and building friendships with the immigrants and refugees who visited Casa. I never expected that over a year



"I could never have imagined discussing life stories, sharing laughter, and building friendships with the immigrants and refugees who visited Casa."



Kacie Shannon grew up in Pittsburgh, PA and studied neuroscience at the University of Notre Dame, an institution that helped inspire her mission to use her personal gifts, experiences, and education in service to justice. As a second-year medical student, she enjoys serving as a manager of The Monday Clinic, a free clinic that serves Spanish-speaking patients. She also helps lead St. Basil's Society for Catholic students. She cherishes investing in efforts related to medical education, mental health, and expanding primary care access to vulnerable groups. In her free time, she enjoys reading and immersing herself in nature, such as camping and visiting National Parks.

later, I still receive occasional WhatsApp messages from former guests – something that further demonstrates to me that the sense of family established under Casa's roof was genuine. My greatest understanding of the resilience of the human spirit is directly attributable to the stories of the migrants I met while sharing a home. Most importantly, I now realize that we all belong to each other in our globalized community of coming and going, giving and receiving, living and loving. With that comes a particular responsibility to take care of our neighbors.

Reflecting now on the privilege of my close encounters with the migration experience, I am astounded by many things. One of which is that for a significant period of my life, I hardly gave a second thought to migration, including the migrants themselves and those who receive them. Despite migration being woven into the fiber of this country's story and the narrative of history, including for my ancestors, I remained ignorant of the reality. It was easy to detach from a social concern that did not directly impact me. But now, it does directly impact me just as it greatly impacts those whom I love: the migrants here, and those on the way.

The arduous adjustment process for a migrant is only possible if it is experienced in a community and aided by compassionate and benevolent actions. To turn away from the needs of fellow brothers and sisters is an injustice. Indeed, there is a role and responsibility that every person can play in this effort by harnessing one's gifts in service towards the common good. Even actions that require minimal effort, such as learning a few words in a migrant's native language so that they feel comforted and welcomed, can make a tremendous impact. Looking someone in the eyes and recognizing their personhood can help them feel seen and heard. Volunteering in places such as free clinics, food pantries, health fairs, or English classes also engenders an opportunity to listen to personal stories from migrants and build relationships. It is in those same spaces where you can bear witness to a hopeful spirit like no other and encounter some of the most courageous among us.

Pictured below: The fence outside Casa Juan Diego depicts a painting of Our Lady of Guadalupe, a significant inspiration for how the household was named. So why Juan Diego? The following explanation in the words of Louise and Mark Zwick, the organization's founders, is borrowed from the CJD website:

"The beautiful story of Our Lady of Guadalupe inspired us to give our houses of hospitality the name of Juan Diego. Who is the woman who changed the face of the Americas? What is the event that changed the lives of millions of poor people and who has helped empower them in a way unheard of before? The conquistadores had convinced everyone that the Native Americans in New Spain (the Americas) were less than human or despised people. But the Lord surprised everyone. He chose a poor Native American person of great faith to evangelize the Native Americans and the Spaniards.

The person chosen was Juan Diego. Mother Mary, the mother of Jesus, now known in Mexico and throughout the world as Our Lady of Guadalupe, appeared to Juan Diego as a brown-skinned Aztec princess and spoke to him in his native tongue, the forbidden language, Nahuatl. She had a mission for Juan Diego. This appearance of Our Lady of Guadalupe changed the face of the Church and radically renewed it. The choice of a Native American as God's messenger meant that all Native Americans are important. There was a new-found, unheard-of dignity for the indigenous and the poor. Juan Diego was given the role of going to the local Bishop to tell him of the importance of the indigenous people. The Bishop eventually heard the voice of the poor and was converted. He asked Juan Diego for a sign. Our Lady gave Juan Diego the sign of roses in December, in the winter, and he gathered them in his cloak to show to the Bishop. When he opened his cloak to show the roses to the Bishop and they fell to the ground, the Bishop fell to his knees because the image of Our Lady of Guadalupe was imprinted on Juan Diego's cloak. The Bishop built the church building that Our Lady had requested through Juan Diego–and through this great event, the Lord built up a Church made up of millions of poor, indigenous people. Our Lady of Guadalupe continues to build up the Kingdom by reminding poor people that they are worthy of an apparition..."

MIGRATION IS NOT A FORM OF LIBERATION

BY AHMED ALSHAIKHSALAMA

"I realized that migration was not liberation. **I had lost years with my grandpa, and the rest of my family."**

Clerkships are over, what a relief! Another year down. I reflected on the last year to myself as I migrated to the blunt end of medical school. While enjoying my well-deserved break from last year, I received the wonderful news: my grandparents were coming to visit all the way from London! I wondered if they developed a British accent after all these years away from home. It would be kind of nice — innit? In the next 2 weeks, plans were made to explore the larger Dallas area: sightseeing (questionable in Dallas), good food, and the many new mosques that had opened recently.

Upon their arrival, I quickly realized my planning was merely a kind gesture. Both grandparents, now in their early to mid 80s, did not have the bandwidth for these experiences. They'd already experienced so much. Time had taken its toll on my grandpa in particular, who now suffered from vascular dementia. I had so much to ask, so much to learn from him. Throughout his stay, he kept trying to communicate, but his speech had become unintelligible. I had missed his voice and forgotten what it sounded like all at once. Between the 1970's and 2000's, he had migrated to Gaza, Iraq, Kuwait, and ultimately London following the Gulf war.

As for us, London was not an option. Still, we were among the lucky few able to migrate to the United States where we would build a peaceful and meaningful life in the following decades. The rest of my extended family remains scattered across Europe, the Middle East, and Gaza. To this day, I still have not met many of them.

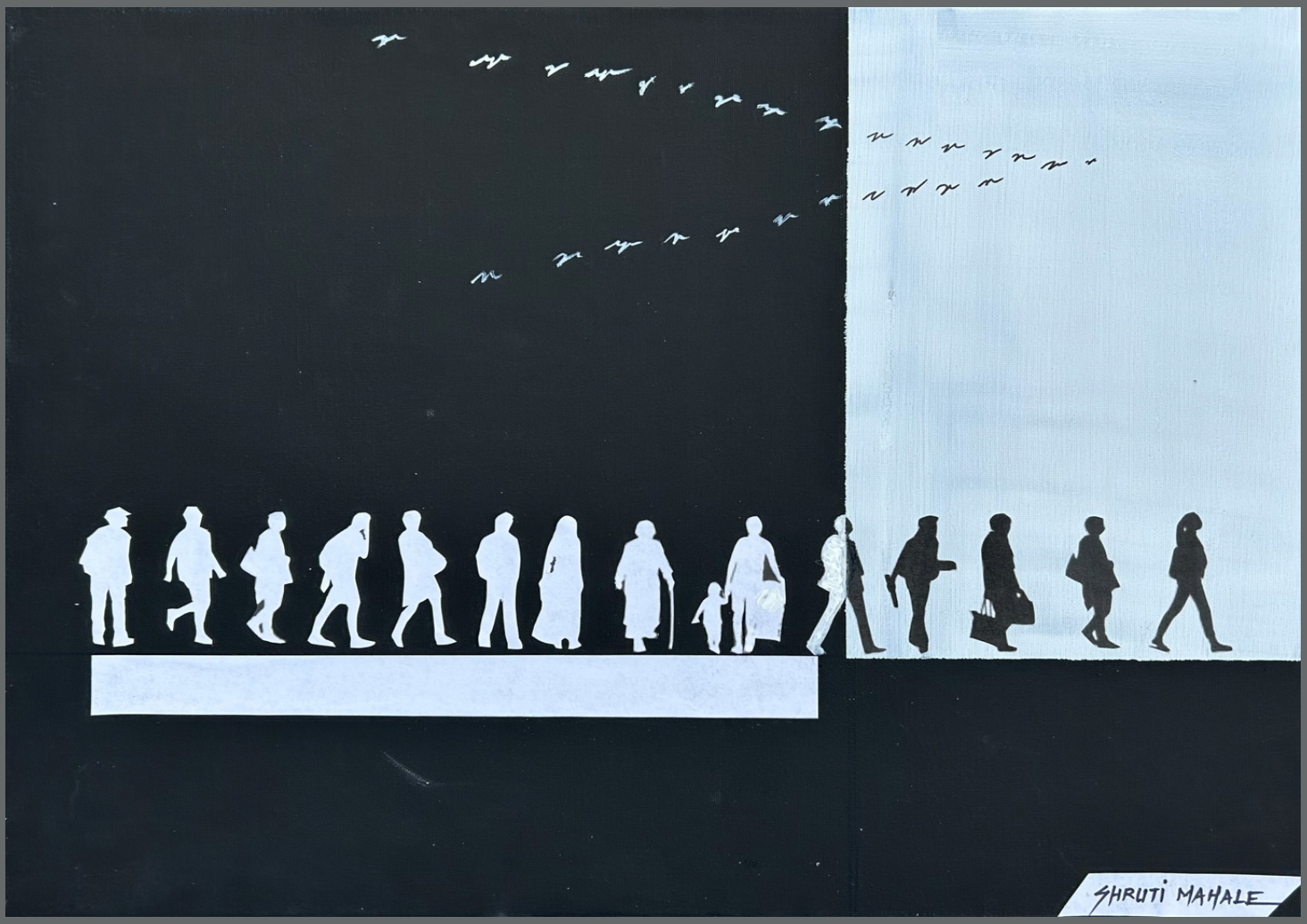
While reflecting on my Grandpa's illness, I realized that migration was not liberation. I had lost years with my grandpa, and the rest of my family. What should have been a support system that contributed to our lives was relegated to occasional phone calls and photographs. We were lonely with no one beyond my immediate family to share our own sorrows and celebrations. Our Eid holidays, our thanksgiving breaks, our graduations, and my own wedding! We had come from a land with generations of support in the pursuit of safety and harmony.

Perhaps these conversations with my grandpa were not meant to be held, because the story continues. Despite our distance, despite the time and place, our faith and our rights never eroded. We hold our flag high over our heads, and we are unwavering in our faith. Our perseverance grows stronger. I carry his legacy, his mannerisms, his values, and his hope for a better future and an opportunity to unite with my family, near and far. You can rest Grandpa, I have not forgotten.

Ahmed Alsaikhsalama is a fourth year medical student. He was born in Gaza and raised across the United Arab Emirates, Sweden, and the United States. His experiences as a first-generation immigrant fostered a deep commitment to introspection and service, driving his advocacy for healthcare access. He is pursuing a residency in Ophthalmology to contribute to global health initiatives and improve healthcare equity, particularly in underserved communities.

3 PIECES BY SHRUTI MAHALE

Artwork: "Migration"
Essay: "Navigating Healthcare Challenges in a New Land"
Poem: "The Journey of a Lifetime"



Migration is largely driven by people who seek to move from a highly challenging environment to a place that offers a brighter future. Using a black-and-white color scheme, I wanted to highlight the contrast between immigrants and their backgrounds illustrating how their position in society shifts as they move to the new environment.

NAVIGATING HEALTHCARE CHALLENGES IN A NEW LAND

BY SHRUTI MAHALE

People migrate from all over the world for various reasons, seeking new opportunities and a better life. However, moving to a new country comes with the challenge of adapting to unfamiliar systems, including healthcare, which is crucial for one's well-being. Navigating healthcare can be complex given the different parties involved and for individuals who are still adapting to a new environment, this can be even more challenging.

The first challenge immigrants face is finding a healthcare provider. Often, new immigrants rely on recommendations from their network—family, friends, or community members—who suggest providers based on personal experiences. Choosing a healthcare provider involves trust and a desire for quality care, making it essential for patients from different backgrounds to find professionals who meet their needs. Many patients are comfortable with providers who have similar backgrounds, similarly, immigrants may appreciate having providers who come from the same community or speak the same language.

The patient-physician interaction is a delicate balance. Physicians have extensive training in diagnosing and treating diseases, but effective communication is critical to successful treatment. Patients need clear information in a language that they understand to make informed decisions. This can be challenging for those who don't speak the provider's language. Interpreters have helped bridge this gap but often in busy hospitals, a translator may not always be available leading to the use of the language line instead. Increasing the number of translators and ensuring they are familiar with the context of a conversation can help reduce misunderstandings.

Navigating the healthcare system can be daunting, even for those familiar with it. Immigrants face additional hurdles when trying to understand the intricacies of the American healthcare system, including how to access services. Questions about cost, insurance coverage, and whether to seek medical attention can be overwhelming, especially for those new to the system.

Payment is another significant barrier. Many Americans receive health insurance through their employers, while others rely on government programs like Medicare and Medicaid. Understanding terms such as 'copay, deductible, and in-network versus out-of-network' can be challenging, especially for those who do not have equivalents in their country of origin. For undocumented immigrants whose status affects their ability to be employed, this becomes an even major challenge.

Cultural differences can also impact healthcare practices. Immigrants come from all over the world and their cultural practices may differ depending on their country of origin. In some countries, annual check-ups are not as common as they are in Western countries, leading to a reluctance to seek medical care or preventive screening. Some cultures may emphasize complementary medicine and for other cultures, there may be a taboo surrounding topics related to reproductive and mental health requiring providers to approach these subjects with care and patience.

Unfortunately, undocumented immigrants face even more significant challenges. Undocumented immigrants may incur injuries on the journey to the US which can be dangerous. Fear of deportation may discourage them from seeking medical care, leading to health risks and potential public health issues. Without legal employment, they lack access to employer-based insurance and their financial resources are limited. Undocumented immigrants seeking asylum may be required to live in crowded conditions, increasing their exposure to communicable diseases. They may also be forced to use emergency rooms for their health issues, which are required by law to treat all patients. However, these costly visits may not provide the best long-term healthcare solutions.

Orientation programs, informational handouts, and employer-based support may help legal immigrants better understand the healthcare system but undocumented immigrants may require additional assistance. Resources are required to guide immigrants through the complexities of accessing care, navigating insurance, and following the providers' advice in between visits. To address the challenges faced by immigrants, systemic changes are needed to ensure that all individuals, regardless of their immigration status, have access to adequate healthcare.

Shruti Mahale is a fourth-year medical student at UT Southwestern. She is originally from the DFW area but did most of her schooling in India before moving back to the US for college. Outside of school, she enjoys painting, singing, writing, doing impressions, and watching films.

the journey of a lifetime

by shruthi mahale

He had dreamt of coffers filled with gold,
The maps were all over the table,
'Adventure' he had told the lads in the tavern,
He knew the stories were true and not just fables,

And the sea was calling to him,
He wanted to be the first to reach the lands,
Perhaps he'd find gold and spice,
He would know once his anchor touched the sands,

Of a shore that held so much promise,
Or maybe they'd reach an abyss and die on the way there,
But did it matter if it were the promises that called him?
To him, those chances seemed fair.

She had slipped out of the house,
With a baby in arms and a child by her side,
When the clouds shrouded the moon,
On the streets, not a soul in sight.

They said to go toward the woods,
Be as silent as a mouse,
This was the town she had lived in all her life,
She'd be leaving these people and her house.

Was it wrong to believe in a different god?
She had lived this way all her life,
All these years, her faith had kept her going,
Who had known there'd be so much strife?

Things were different ten years past,
It was hard to pinpoint when things changed,
Now law and order were non-existent,
Now Anarchy and violence prevailed.

He didn't know what to do,
His kids could die on the street,
As they were coming home from school,
Shot in cold blood in the dusty heat,

Or God forbid as they slept at night,
In their beds side by side,
What a quandary he was in,
He could not live if they died,

And so, they must walk to the promised land,
They may die trying but he had made a vow,
They would walk together through everything,
And that sliver of hope was enough for now.

ENRIQUE ARREDONDO

We exist, **and we matter too.**

I come from a border town called Edinburg, Texas, which is approximately 20 miles from the border. Edinburg is located in the Rio Grande Valley (RGV) region. In 2019, approximately 91.5% of the population in the RGV was Hispanic, and more than 25% of the 1.3 million Hispanics living in the RGV were immigrants (1). According to the American Immigration Council, in 2019, Hispanic households earned $19.1 billion in income, with $2.6 billion going to federal taxes and $1.7 billion going to state and local taxes, leaving them with $14.8 billion in spending power that can be reinvested in local communities (2). However, even though Hispanic immigrants are contributing to the economy, society, and local community, the question remains as to why they still can't get proper healthcare and maintain consistent care. According to the US Census Bureau, about 30% of individuals living in the RGV are uninsured (3).

Coming from a family of Hispanic immigrants who moved to the U.S. seeking better opportunities, I have witnessed firsthand the challenges my family members face in accessing healthcare and securing a primary care physician. To provide insight into how Hispanic immigrants navigate and perceive the healthcare system, I asked a family member the following questions and recorded their answers below. To protect their privacy, I have not included their name or details about our relationship.

Enrique Arredondo is a second-year medical student with a Bachelor of Chemistry from the University of Texas Rio Grande Valley (2019) and a Doctor of Pharmacy degree from Texas A&M School of Pharmacy (2023). Originally from Edinburg, Texas—a community with a predominantly Hispanic and Spanish-speaking population—Enrique is passionate about serving underserved populations and promoting health equity. His medical interests lie in cardiothoracic surgery and interventional cardiology. He is also deeply committed to empowering younger generations, especially those facing socioeconomic barriers, by supporting their educational and life goals. Enrique enjoys running, working out, watching TV, hiking, and visiting coffee shops outside of his academic pursuits. I want to thank my family for supporting me and helping me get to this point in life.

I am a 47-year-old Hispanic female born in Monterrey, Nuevo Leon, Mexico. I first moved to the United States in 1997 roughly 27 years ago. One of my challenges here in the U.S. as an undocumented immigrant is the fact that I do not have health insurance and the options available are not affordable. I have not had regular checkup because most physicians see patients that do have insurance. There are health fairs, but it is a day's chore to attend and be seen at these health fairs. The physicians that do accept patients without insurance are quite expensive just for the consultation is out of my budget much less getting labs and tests done.

Lately I have been feeling tired and I am experiencing some symptoms like heart palpitations, insomnia, abdominal pains, hot flashes, hair loss and inflammation of the neck area on the right side. The thought of all the tests and labs that the doctor will probably order scares me from getting checked.

In the past 20 years, I have visited a doctor's office about two to three times only. The deprivation of not having a primary care physician has greatly impacted my daily activities, since sometimes I feel sad and impotent not knowing what is wrong with me or if something is really wrong with me. My mental health would be in a different place if I had that peace of mind of going to a doctor on a regular basis. I am in a stage of my life where I know the changes my body is going through affects how I feel on certain days, which is preventing me from spending quality time with my spouse and/or children.

The stereotype is that sometimes people make you feel like less of a human being by not having medical insurance. Staff at some doctors' offices are also contributing to this depressing situation when they give you second rate service simply for not having insurance.

Soy una mujer hispana de 47 años nacida en Monterrey, Nuevo León, México. Me mudé por primera vez a los Estados Unidos en 1997, hace aproximadamente 27 años. Uno de mis desafíos aquí en los EE. UU. como inmigrante indocumentado es el hecho de que no tengo seguro médico y las opciones disponibles no son asequibles. No me he hecho chequeos regulares porque la mayoría de los médicos ven a pacientes que sí tienen seguro. Hay ferias de salud, pero es una tarea de un día asistir y ser visto en estas ferias de salud. Los médicos que aceptan pacientes sin seguro son bastante caros, solo porque la consulta está fuera de mi presupuesto, y mucho menos para que me hagan análisis de laboratorio y pruebas.

Últimamente me he sentido cansada y estoy experimentando algunos síntomas como palpitaciones cardíacas, insomnio, dolores abdominales, sofocos, pérdida de cabello e inflamación del área del cuello en el lado derecho. La idea de todas las pruebas y análisis de laboratorio que el médico probablemente ordenará me asusta para que no me hagan el chequeo.

En los últimos 20 años, he visitado el consultorio de un médico solo dos o tres veces. La depravación de no tener un médico de atención primaria ha impactado mucho en mis actividades diarias, ya que a veces me siento triste e impotente al no saber qué me pasa o si algo me está pasando realmente. Mi salud mental estaría en un lugar diferente si tuviera esa tranquilidad de ir al médico de forma regular. Estoy en una etapa de mi vida en la que sé que los cambios por los que está pasando mi cuerpo afectan cómo me siento en ciertos días, lo que me impide pasar tiempo de calidad con mi cónyuge y/o mis hijos.

El estereotipo es que a veces las personas te hacen sentir menos ser humano al no tener seguro médico. El personal de algunos consultorios médicos también está contribuyendo a esta situación deprimente cuando le brindan un servicio de segunda rabia simplemente por no tener seguro.

The cost of health insurance is almost unattainable as an undocumented immigrant with the wages we earn. Some doctors will not see uninsured patients and those that do are over saturated with patients, so time is critical and some have to miss a day's worth of work just for a consultation alone.

Americans that have insurance see it as right instead of a benefit, since most obtain insurance through their employer. Immigrants are not afforded the same privilege since we can't hold a job legally and therefore do not have that benefit of health insurance.

I would like to see immigrants to see a physician that is part of some program, if there isn't one already, that offers affordable rates and/or payment plans. I would like medical students to know that Mexican immigrants are hard working people just to make ends meet. We would like to be afforded health insurance that is reasonable with our wages. Sometimes the status of our health is not because we don't want to follow certain treatments or go to our follow ups; it is because we sometimes cannot afford the visit, treatments, or get there.

Lastly I recommend approaching ALL immigrant patients (not necessarily just Mexican immigrants) with care and kindness. Most of the time it may be our first time seeing a doctor and we are just scared of what may be causing our symptoms. We just want to be seen as humans as well.

El costo del seguro de salud es casi inalcanzable como inmigrante indocumentado con los salarios que ganamos. Algunos médicos no atienden a pacientes sin seguro y los que lo hacen están sobresaturados de pacientes, por lo que el tiempo es crítico y algunos tienen que perder un día de trabajo solo por una consulta.

Los estadounidenses que tienen seguro lo ven como un derecho en lugar de un beneficio, ya que la mayoría obtiene el seguro a través de su empleador. A los inmigrantes no se les concede el mismo privilegio, ya que no podemos tener un trabajo legalmente y, por lo tanto, no tenemos el beneficio del seguro médico.

Me gustaría que los inmigrantes vieran a un médico en algún programa, si aún no hay uno, que ofrezca tarifas asequibles y/o planes de pago. Me gustaría que los estudiantes de medicina supieran que los inmigrantes mexicanos son personas trabajadoras solo para llegar a fin de mes. Nos gustaría que se nos permitiera un seguro de salud que sea razonable con nuestros salarios. A veces el estado de nuestra salud no se debe a que no queramos seguir ciertos tratamientos o acudir a nuestros seguimientos, es porque a veces no podemos permitirnos la visita, los tratamientos o llegar allí.

Por último, recomiendo acercarse a TODOS los pacientes inmigrantes (no necesariamente solo a los inmigrantes mexicanos) con cuidado y amabilidad. La mayoría del tiempo estamos consultando un doctor por primera vez y sentimos miedo de saber que es lo que causa los síntomas. Lo que pido es que nos traten como humanos también.

"I recommend approaching ALL immigrant patients (not necessarily just Mexican immigrants) with care and kindness. Most of the time it may be our first time seeing a doctor and we are just scared of what may be causing our symptoms. We just want to be seen as humans as well."

"Por último, recomiendo acercarse a TODOS los pacientes inmigrantes (no necesariamente solo a los inmigrantes mexicanos) con cuidado y amabilidad. La mayoría del tiempo estamos consultando un doctor por primera vez y sentimos miedo de saber que es lo que causa los síntomas. Lo que pido es que nos traten como humanos también."

Pick up a Pencil

With a mom born in Pakistan and a dad whose family journeyed from India to Mozambique before finally settling in Portugal, my home has always been a rich tapestry of diverse music, foods, and languages. Amidst these cultural differences, one constant has been the paramount importance of education. My parents, migrants seeking better opportunities, made tremendous sacrifices to ensure my education was meaningful and purposeful. This dedication to learning has been the most significant and unifying element of my upbringing, underscoring the transformative power of education in the context of migration.

In a world when information sleeps beside us charging for hours,
We perhaps have forgotten the ultimately power
That flowers when we touch it and never truly dies,
Until only ignorance waters it and we say goodbye.

Education is the final station,
Leading us to a destination far from our conception.
But do we choose to delve deep into what we do not know
Or simply get off at an earlier station?

When we pick up a pencil and choose to learn,
We engage in a conversation we alone can churn,
Knowledge is simply a steering wheel
We must learn how to turn.

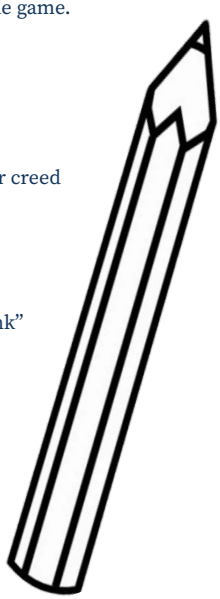
So as we dive into this year with a pandemic in our midst,
Why should we stop and resist?
The knowledge that awaits us if only we looked,
The knowledge that could be ours if only we shook
Shook ourselves out of a slumber it is far time we rose from,
To enter a world of innovation that tells us to come.

Education is a choice,
A decision we make,
To rejoice with the unvoiced
And help their voices be saved.

No longer waiting silently besides,
Waiting for permission
Instead,
We speak.
We speak to each other with purpose and passion,
That although we cannot not all, we know something of change
We can speak the language of all, of education
Not with frustration but with imagination
Ready to absorb all that we know not.
Releasing our minds, never allowing it to rot.

Rotting from misinformation that always surrounds us,
But when we choose to read, we take out the crust,
The crust that develops when we stop growing,
The crust that develops when we stop hoping.
Education is what breaks,
The cycle of poverty that we must replace,
We must chase the key that unlocks this door,
It is education, the very thing we ignore.

For when we learn only for the sake,
Of money and fame,
We last only for a little while in the flame that runs the game.
For when we learn for the sake of sparking hope,
We provide a rope,
That doesn't simply give, but teaches,
That doesn't simply preach but provides.
No matter the tide that comes washing over,
Education is the eternal protector,
The one thing you carry, no matter your color class or creed
The one seed
That you can continuously feed
Never becoming a weed
But instead growing to fit your every need,
Never allowing you to recede from conversation,
But instead forcing you to unapologetically say "I think"



To succeed we need do only this deed,
Dive without fear into a world that will teach us
That color, class or creed is a plus
That will force us to discuss
The beauty within all,
And never again crawl into a wall that divides us,
But rather unites us
To a table that has a chair for all,
Because justice isn't a privilege for one,
It is a right for us all.

Education isn't ephemeral,
It is an eternal right.
For when we engage in its beauty,
Our humanity will shine bright.

Home

Home is a four-letter word I've always been incredibly fascinated with. It's a seemingly simple word that evolves in its definition as we age. As a young girl, home existed in a suburban town; in college, I started to feel like home was a collection of my closest friends over the 4 years of sitting in classrooms- home became a group of people.

A few summers ago, I had the opportunity to visit my parents' homes, both in Karachi, Pakistan and in Lisbon, Portugal where my mom and dad, respectively, spent their childhoods. Although these trips were eye-opening in so many ways, it made me feel oddly distant. As someone who has truly never moved away from the small suburb where I grew up, my parents had experienced huge waves of migration to escape civil war and unrest- their definition of home had been forced to change. I, on the other hand, had had the luxury of stability, and peace. Visiting the streets where my dad played soccer or where my mom and her friends would go to drink mango lassi after an exam made me realize that although their histories were something I may never relate to, it is most definitely, still a part of who I am and how I've been raised. **After those trips abroad, I realized that the definition of a physical house may change quite a few times in my life- but the people who make even the smallest space feel like the most comfortable, will be the only true definition of home to me.**

Last summer, I had the privilege of being a facilitator for a camp called Global Encounters (GE); this program takes students from all over the world to one location, which, in this case, was Mombasa, Kenya. The program's three pillars were 'service, leadership and culture'. In our specific camp, approximately 117 participants came from all over the world to the Aga Khan Academy in Mombasa to learn from each other and the community around them. It was here when my own definition "home" truly changed.

Every participant at GE was assigned a service site, and mine was the Unity School, a community based learning environment in Mombasa. Our goal during that trip was to work with the principal and local teachers/students to identify what gaps we could fill, whether that be in the field of student clubs, sports, development of an English curriculum or the arts. After many days of conversation, deliberation and budget consultation, our students decided to work on three major projects. These comprised building a physical stage where students could perform their talents, developing a UN model debate club to improve public speaking skills, and developing a list of commonly used teaching methods that were proven to increase engagement in the classroom. Throughout those eight days, we worked tirelessly to ensure that the supplies we were using were sustainable, that our debate club had a sponsor, and that we were experimenting with various teaching practices with the 4-8th graders.

The purpose of this project was to experience a snapshot of what the development process looked like and how each member of a community had a role to play, rather than outsiders coming in with a savior complex. After coming back to the US, I realized that, although I had never been to Kenya before, I had felt completely at home there, whereI worked with brilliant minds from all over the world.. Why had I felt that way? Why did it feel like my home had shifted or perhaps changed?

After much reflection, I realized that our definition of home can be a feeling or experience as well—and to me, it came in the form of service. **Working with the youth and giving my time to understand global development fueled my spirit and made me feel at "home," although I was miles away from my house**. Therefore, home, to me, is simply where we feel like our best selves; whether that's at a rave or in the quiet corner of our house; home can be anyone, anywhere, or any feeling that lifts us and makes us believe that we belong no matter what.

Where is home for you?

BY AHMET TOPRAK

NAVIGATING CULTURAL NUANCES IN MIGRANT HEALTHCARE

Medical professionals are frequently reminded of the importance of conducting a thorough history and comprehensive physical exam while avoiding the pitfall of placing patients into preconceived categories. While this principle is widely accepted, its practical application in the context of migrant health can be particularly challenging. Clinicians must draw from their experiences to make timely diagnostic and treatment decisions. However, while avoiding biases is crucial, some level of generalization is inevitable and necessary in public health. This essay explores the delicate balance between necessary generalizations in public health and the importance of individualized patient care, particularly in the context of migrant healthcare.

It is crucial to consider how our thoughts, interactions, and differential diagnoses might change if our patients come from different backgrounds. Many biases arise from inaccurate or sensationalized media portrayals. However, these biases are not simply the result of ignorance; they can also be shaped by our education, exposure to objective information, and nuanced understanding of cultural narratives. Thus, while biases are often viewed negatively, they can also be a product of our attempts to navigate complex cultural landscapes in healthcare.

Yet, making general assumptions about populations is an essential aspect of public health. These assumptions help us understand socioeconomic issues, identify cultural barriers, predict economic obstacles to healthcare access, screen for infectious diseases, address epidemiological risk factors, and tailor our communications with patients. When our assumptions about patients are validated, we might view them as 'clinical experience' or 'cultural competence,' but when they are not, we often dismiss them as 'bias' or 'preconceptions.' This dichotomy highlights the complexity of applying generalizations in a way that benefits patient care without reinforcing harmful stereotypes.

Doctors are trained to emphasize bias awareness, refine their communication skills, and focus on establishing rapport with their patients, making the healthcare process as pleasant as possible. These practices have been effective, as seen in a large international 2019 poll that ranked physicians as the most trusted profession in both the United States and the world. However, despite this trust, physician distrust and healthcare dissatisfaction are at an all-time high, particularly in immigrant communities. This distrust is associated with worse health outcomes and lower rates of healthcare satisfaction. Negative interactions with clinicians are a significant reason for poor follow-ups and low participation in general health maintenance. The roots of this distrust often lie in misapplied generalizations, where assumptions about a patient's background lead to communication breakdowns or inappropriate care.

In a world with limited time and resources, the fast pace of healthcare today makes it impractical to conduct exhaustive histories for every patient. However, this need for efficiency can lead to logistical difficulties and negative social repercussions when assumptions based on a patient's background are inaccurate. For example, while it might be reasonable for a doctor to ask a Somali refugee about malaria prophylaxis, the same question might irritate a Ukrainian refugee, even though it's not impossible that they too have been in an endemic region. This extreme example illustrates how bias can prevent us from wasting time on irrelevant questions, but it also shows how such assumptions can backfire. Similarly, asking a patient from Southeast India about betel nut consumption could be a sensible decision that might prevent cancer, but it could seem odd to a patient from a different region. These examples underscore the challenge of balancing efficiency with cultural sensitivity in clinical practice.

When cultural stigma is involved, communication becomes even more complex and potentially abrasive despite our best efforts. For instance, an immigrant relative of mine, a devout Muslim from

a cultural background that heavily stigmatizes premarital sex, was offended when their family physician recommended an HPV vaccine for their 16-year-old son after explaining that HPV is a sexually transmitted virus that can cause cancer. This recommendation led to a confrontational response when the son agreed to vaccination. In acute settings, where tensions are amplified, these complexities become even more pronounced. For example, a homeless man experiencing angina might understand why he is asked about PCP abuse, while a housed patient with the same symptoms might find the question neglectful, disrespectful, and unhelpful. These scenarios illustrate how deeply personal and cultural factors can influence the perception of medical advice, making the need for culturally sensitive communication all the more critical.

These challenges are not just relevant to taking patient histories or determining public health policies but also to how we communicate medical information. Overexplaining or underexplaining based on assumptions about a patient's education or healthcare literacy can lead to miscommunication and suboptimal care. Tailoring interactions based on who the patient is, rather than where they are from, leads to better healthcare outcomes. This approach, while time-consuming, is essential in avoiding the pitfalls of generalization and ensuring that care is both effective and respectful.

The individual variability between patients of the same background, as well as the differences across various regions, can be profound. For example, Istanbul is known as a medical tourist hotspot and is by far the most frequently traveled destination in Turkey. As a result, it's easy to generalize that the rest of Turkey would have a similar level of medical literacy and healthcare advancement. Growing up in Istanbul, I experienced firsthand the benefits of a modern healthcare system. The city's hospitals are equipped with state-of-the-art technology, such as robotic surgery systems and advanced imaging techniques. Telemedicine is widely used, ensuring that residents receive timely and accurate care that meets global standards. These experiences could easily lead one to assume that healthcare in Turkey is uniformly sophisticated.

However, my summers spent in Serinhisar, a small rural village, presented a contrasting reality. Here, a single physician was responsible for the healthcare needs of over 13,000 residents, resulting in minimal access to medical services. The local culture emphasized self-sufficiency, with families managing their own healthcare. On our family farm, for instance, we administered vaccinations to our livestock and processed meat without formal oversight. Realistically, this meant we had a high risk of contracting food-borne illnesses and parasites. I even remember having a tapeworm as a child after spending time in the village, which may be attributed to these practices. These activities, while routine in Serinhisar, might seem unusual or concerning to someone only familiar with urban medical norms. This personal experience highlights the risks of oversimplification in assessing migrant health profiles and reinforces the need for healthcare providers to consider the specific cultural, social, and economic factors that shape each patient's health behaviors and beliefs.

By listening to and reflecting on patients' stories, physicians can gain a deeper appreciation of the diverse experiences that shape health outcomes. This approach not only enhances patient care but also fosters a more empathetic and culturally competent medical practice. In conclusion, while avoiding categorical thinking in medicine is a complex challenge, engaging with individual narratives that reveal the nuanced realities of patients' lives is key. Tailoring medical interactions based on the individual patient rather than ge-

"By listening to and reflecting on patients' stories, physicians can gain a deeper appreciation of the diverse experiences that shape health outcomes."

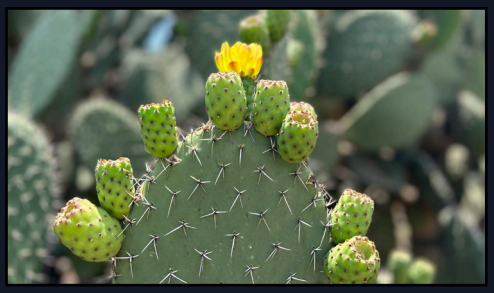
Ahmet Toprak is a 3rd-year medical student at UT Southwestern Medical Center. He graduated Summa Cum Laude with a B.Sc. in Biomedical Sciences from Texas A&M University in 2022. His research interests include hematology, oncology, genomics, and synthetic biology. In his free time, he enjoys socializing with friends, training Brazilian jiu-jitsu, playing chess, and kickboxing.

My Journey as an International Student

AIXA X. ANDRADE

I am a graduate student at the University of Texas Southwestern Medical Center (UTSW), originally from Mexico City. My mother always said, "You come from a family of migrants." My maternal grandmother immigrated to Mexico City from a rural area in the municipality of San Miguel de Allende, which was not as famous as it is today. There were many needs in the countryside, so she migrated to have the opportunity to work. She started by cleaning houses, but after marrying, she was able to open a "comida corrida", which is what small businesses in Mexico that offer a fixed menu with soup and an entrée for everyone are called.

My father arrived in Mexico from Buenos Aires (Argentina) around 1990. His grandparents emigrated from different places. I know that I have a Yugoslav great-grandfather from a country that no longer exists and a Spanish great-grandfather from the autonomous community of Galicia. The rest of my Argentinean family descends from various places in Europe.



I left Mexico not only because I wanted to explore the world, but also because I was frustrated with the country. I had applied for a Master's degree at the National Autonomous University of Mexico (UNAM), where I had completed my undergraduate studies, but was not accepted. Finding work with a Physics degree was challenging in Mexico. Eventually, I secured a position as a data scientist in the industry, but felt dissatisfied with the work. My job involved analyzing sales and product distribution data and developing pipelines for resource optimization. In Mexico, the workweek is 48 hours long on average, which is more than in the U.S.A. In addition to the long hours, I had a very long commute of two hours each way. My long days left little time to develop my personal interests.

My desire to continue studying remained strong because I truly enjoy learning new things. Therefore, I applied for a Master's degree in Medical Physics at McGill University in Canada. To my surprise, I was accepted. I did not think twice about going and arrived in Montreal, Canada, at the end of the summer of 2018. Adjusting to this new place was extremely difficult: I was not used to the cold, the cultural differences were overwhelming, and it was not easy to make friends. I had my first reality check when I arrived at an Airbnb that I had rented with a girl who was also looking for a roommate and starting at McGill that fall. We discovered bed bugs in the Airbnb after the first night and had to evacuate quickly. Montreal, being a city with five universities and a college, attracts many international students due to Canada's supportive stance on migration. This high level of student mobility means that unfortunately, every place was full, and we struggled to find accommodation within our budget for that night. I saw a Facebook advertisement for a lease transfer and called. I begged the person to rent us the place for a month while we looked for something permanent and, finally, he agreed.

It was a tough month because, in addition to really missing my family, living with almost nothing hit me hard. I started out sleeping in a sleeping bag before moving to an inflatable mattress. I had no furniture and didn't plan to buy any until I found a permanent place. Finally, I found a good apartment and started a new routine. However, integrating into this new normal proved very challenging. Everything was new. The classes, work, and presentations were all in English, even though I had never given a presentation or written an assignment longer than one page in English before. As everyone can imagine, it was an initial struggle for me. The very long winter, with snow becoming normal, added to the loneliness. When summer arrived, it felt like being reborn, and in Montreal, they celebrate summer like nowhere else in the world. The entire summer is a party, with festivals, music everywhere, and street events.

In the end, I managed to adapt to Montreal until the COVID pandemic hit during my last year of the master's degree, which shifted to remote learning. Despite living with roommates, the loneliness during the pandemic lockdowns became overwhelming. I got accepted into the Ph.D. program in Biomedical Engineering at UTSW. Unfortunately, moving to Texas during the pandemic was challenging, and I had to postpone my entry into the Ph.D. program for one year. However, not all the news was bad! I got to spend some time back in Mexico, which I thoroughly enjoyed. Despite leaving Mexico in frustration, I quickly discovered just how wonderful it is after being away for so long. It is bustling, friendly, cheerful, and fun, with diversity and culture everywhere, and the food is incomparable. I truly missed it. Most importantly, I was so happy to spend time with my family!

I finally arrived in Dallas, Texas in August 2021 to start my PhD in Biomedical Engineering at UTSW. Dallas has been welcoming to me. There are many Mexicans here, and Spanish is spoken everywhere. The city has its little Mexican corners that make me feel at home. The change was smoother. Montreal trained me for the hard life and life in Dallas is pleasant.

It hasn't been hard for me to adapt. The heat of Texas contrasts with the cold of Montreal, but I prefer it. In the apartment where I live, there is a wonderful pool and last summer I spent my time between the pool and the grill. Now my English is much better than when I first arrived in Canada. I still have to practice my presentations and rehearse a script because improvising is still hard for me.

I really enjoy my research in the Deep Learning and Precision Health lab directed by Dr. Montillo. We focus on developing algorithms and applications of artificial intelligence for biology and medicine. Every day, I go to the lab to write code, read scientific papers, and engage in scientific research.

In both Canada and the U.S.A., I have encountered many migrants, including international students like me. The diversity has helped me to feel at home. In Dallas, both inside and outside of school, the presence of immigrants is evident. It is quite common to hear Spanish spoken in stores since many residents are either immigrants themselves or have ancestors who were. This has helped preserve their language. Dallas truly showcases the richness of migration, teeming with vibrant traditions from Mexico and Latin America.

My experience as an international student has been tough, but I have learned a lot more than just the science behind my PhD. I have learned about what life is like in different countries. I have also learned that not everything is black or white and that each country has its positive aspects along with specific problems. Additionally, I have learned to manage my loneliness and become completely independent while integrating into the local community. When someone migrates and faces difficulties, they have to learn to take things one day at a time, poco a poquito.

Originally from Mexico, Aixa Andrade is a fourth-year Ph.D. candidate in Biomedical Engineering at UT Southwestern Medical Center. She specializes in the development of artificial intelligence models to address biological and medical questions. In her free time, she enjoys traveling, dancing, painting, and exploring new cuisines.

Where are you from?
Embracing My Transcontinental Identity

BY TAMMY SOLA-ODESEYE

I was 17 years old when I left the life I knew behind and moved from Nigeria to the United States on my own. Relocating to a new country is inherently challenging, but moving to a place where I knew no one and as a teenager presented a unique set of challenges.

As someone who thrives on planning and preparation, I anticipated the obstacles that lay ahead and took steps to mentally prepare myself for them. Aware that the time difference would complicate staying connected with loved ones back home, I arranged for my mother to call me every morning to ensure we did not miss our daily conversations. Making friends in a new country seemed daunting, so I joined every student organization I could once I arrived on campus. And school? I was determined to excel. I studied day and night, attended office hours diligently, and practically lived in the university's tutoring center. You see, I knew the journey would be difficult but I believed I was prepared to face whatever came my way.

When I first visited Nigeria after spending a year in the U.S., I was shocked. The country looked the same, but something felt off. As I rode from the airport to my house, it hit me—I didn't recognize it anymore, and maybe I didn't recognize myself in it either. Although difficult to explain, it was a weird feeling that stuck with me throughout my visit

When friends and family visited, they remarked in our native language, 'You've changed so much'. I struggled to respond particularly because I didn't think I had changed that dramatically. As we caught up, I realized there were numerous inside jokes and shared experiences that had occurred while I was away, making me feel like an outsider trying to catch up. Even my mom had taken over my closet for her clothes, and my old clothes had been donated because they would no longer fit me. Physically and emotionally, I felt like I was in this in-between space. It had only been a year, but the place where I grew up no longer felt quite like home. It was a strange and disorienting experience to have been displaced from my nativity.

I haven't returned to Nigeria in six years, and during that time, I've only become more disconnected. Whenever I meet someone new, they inevitably ask, 'Where are you from?'. It's meant to be a harmless conversation starter, but secretly, I wish they wouldn't ask. The truth is, I don't know how to answer that anymore. Over the years, I've lost touch with many of the friends and family I grew up with in Nigeria, and I'm not even sure if I can call it home anymore. Should I say I'm from the U.S.? Well, that wouldn't be entirely accurate either. I don't feel like I have a home here, particularly with the absence of my family. Every holiday season brings dread as people inquire, 'Are you going home for the holidays?' It's just another painful reminder that I'm not sure where 'home' is anymore. Of all the challenges I expected to face, this was one I didn't foresee.

As I approach the milestone of a decade since leaving Nigeria, I find myself seeking solace in the evolution of my identity and in the realization that a home transcends borders and is not always a physical place. So, where am I from? The answer to that still eludes me, but I am embracing the ongoing journey of discovery and living fully in each moment along the way.

Tammy is a fourth-year medical student who is applying to internal medicine and eventually hopes to pursue a fellowship in hematology-oncology. She is originally from Lagos, Nigeria where she spent the first 17 years of her life before moving to Austin, Texas where she attended college at the University of Texas at Austin and obtained her undergraduate degree in Biochemistry. Tammy is passionate about addressing health care disparities, participating in global health initiatives and she values the opportunity to inspire and support others through mentorship. In her free time, she enjoys reading African fiction, attending Zumba workouts and cooking cuisines from around the world.

Scars and Solutions: Navigating Isotretinoin Treatment Across Continents

Eyes closed, I sensed needle pricks across my face as the physician hovered over me to provide treatment. After drawing my blood, the doctor began to apply some of it back onto my skin. As a sixteen-year-old, I had no idea what was going on, but I just hoped it would heal me. This was my first ever experience of obtaining platelet-rich-plasma (PRP) treatment in Gurugram, India, to heal my horrible acne scarring.

Let me take a step back and walk you through my journey of migration and treatment of chronic cystic acne. Growing up in Gurugram, India from the age of six to fourteen, skin was never something I struggled with—let alone thought about twice. This all changed when our family moved to Singapore for the next four years. Within two years, I had developed unrelenting painful bumps all over my face that refused to stop: being young, I presumed it would vanish and that life would return to normal. This could not have been further from the truth.

Dealing with a chronic condition across countries opened my eyes to the stark differences in healthcare systems across countries and the role of migration in continuity of care. In Singapore, I was prescribed a mild dose of 10 mg oral isotretinoin daily. Isotretinoin (also called Accutane) is the current strongest medication for cystic acne that produces long-term symptom improvement by shrinking sebaceous glands, increasing cell turnover, and reducing inflammation. However, it is hepatotoxic and teratogenic and thus requires careful dosing.

The 10 mg dose slightly helped my symptoms, until I went to India to visit family. Here, I saw a dermatologist, and my dose shot up to 40 mg. Each country took a different approach to treatment: Singapore was more conservative and cautious, while India was more flexible and targeted. Since I was only visiting India this time, I obtained a lump sum pack of the medication with little follow-up liver enzyme testing, pregnancy testing, and education. This disruption of continuity due to my migration across countries led to strong permanent long-term effects.

The moment my symptoms cleared, I started using the rest of my Accutane pills like candy, taking one when I started noticing acne and then stopping again once it was gone. I had no idea that accutane dosing was by weight and that the full course must be completed, even if symptoms seemed to have resolved. My lax approach to isotretinoin kept my acne at bay as I migrated to the US to study in Houston, up until the end of my first year of college—when the pills ran out.

It therefore should not have been a surprise to me when the bursts of pustular cystic acne came back—this time, much worse—during my junior year of college. It filled every possible part of my face, reaching places that I didn't even know could be affected. Even the slight brush of wind against my face would produce prickly stings that shuddered throughout my whole body. Nothing would stop it: I tried every over-the-counter medication on the planet, until I was finally able to see a dermatologist to start on 40-mg daily isotretinoin, again.

This time, however, I was not migrating across countries, so it was done right. I completed my liver enzyme and pregnancy tests, attended follow-up visits, and finished my dosing within a year. Nevertheless, the long-term damage to my scars and self-esteem was irreversible. One PRP session and five microneedling treatments later, I am still in the process of healing.

One of the biggest challenges in long-term care for chronic conditions in people who move countries is continuity of care and education. When possible, inquiring about one's prior migration or future travel can make or break the future care that they receive. Additionally, a greater understanding of country-specific regulations on the dosing and laboratory testing of medications can help provide a more informed, smooth, cross-country transition of treatment. As a future physician, I aspire to continuously expand my knowledge about therapeutic norms worldwide and promote a global exchange of dialogue to optimize treatments in this heightening era of globalization.

Mayuri Vaish is a second-year med student. Born in Chicago, she lived in California for six years, India for eight, and Singapore for four before studying at Rice University. Her global upbringing led to a strong passion in_ serving diverse populations, and her experiences led her to an interest in dermatology. She enjoys exercising, coffee/food with friends, and attending concerts.

From Anthropologist to Director for Refugee Health: Interview with Dr. Lance Rasbridge

If you asked Dr. Lance Rasbridge whether he would ever become the Refugee Outreach Program Director for Parkland Hospital, his answer would likely be no.

In the mid-1980s, Dr. Rasbridge, or perhaps simply Lance at the time, was a graduate student at Southern Methodist University studying medical anthropology. His biology major during his undergraduate years intersected well with his interest in anthropology, resulting in Dr. Rasbridge's unique focus on studying iron nutrition, feeding practices, and cultural change among communities across the globe. Dr. Rasbridge initially did some investigation in French Polynesia, but—almost as a serendipitous call to his current position—he never obtained the funding to return there. At the same time, Cambodian refugees were being resettled in East Dallas which was where he lived at the time.

Almost as if it was meant to be, Dr. Rasbridge realized that he did not need to go overseas to study culture change and feeding practices; there was a strong refugee population within his own city. It only felt right to work with them and learn about their culture. So, Dr. Rasbridge undertook the vast effort to prepare to work with these populations. He spent over a year learning Cambodian and studying its culture until he became fluent enough to even translate from Cambodian to English.

"I would accompany Cambodian mothers to their postpartum visits and visits with their infants, and translate for them in the process," he remembered.

Naturally, building these relationships led to the growth of a strong rapport with the Cambodian community and, more importantly, the board members and staff of the health clinic where the patients were being served. This clinic, funded by a Jewish organization, was called the "East Dallas Health Coalition Clinic."

Again, Dr. Rasbridge happened to be at the right place at the right time, as if fate has destined his future position. In the late 1980s, while he was finishing his Ph.D. dissertation, Parkland Hospital began to develop their community oriented primary care system. They recognized his immense presence in helping refugee communities, and asked whether the East Dallas clinic could become its first ever "Community Oriented Primary Care Clinic," also called a COPC clinic.

With no more need for fundraising, this decision was a win-win for the clinic and for Parkland. However, there was one more hurdle to overcome. This new partnership would result in services for the whole East Dallas population, which would resultantly dilute care for the refugees in the Southeast Dallas region.

As a recent PhD graduate searching for a niche job, this problem created a unique opportunity for Dr. Rasbridge. In 1992, he proposed starting a small program to maintain the unique healthcare provision for refugees that he had been working with for so long, so that their care wouldn't get lost in the sea of the East Dallas patient population.

This led to the launch of the East Dallas Clinic, which eventually led to the formation of Parkland's Refugee Health Clinic at UT Southwestern, as it is known today. Dr. Rasbridge's experience with anthropology taught him that successfully providing medical care revolved around accessibility for patients. At the same time, he was aware of changing times, where the East Dallas region became gentrified and refugee agencies began to place refugees in various regions of Dallas—Oak Lawn, Richardson, Spring Valley, Coit, and, more recently, in Vickery Meadow.

Thus began the initial refugee-focused clinic, a small, two-bedroom apartment complex in the Vickery Meadow region. This clinic was in the heart of refugee communities, conveniently within walking distance from their homes.

At the same time, Dr. Rasbridge had built a close relationship with the Dallas County Health Department, which was responsible for providing medical screenings for newly arrived refugees in the region such as immunizations, comprehensive physical exams, and infectious disease testing. Patients with chronic disease not related to public health, such as diabetes, hypertension, and orthopedic problems, were referred to Parkland for further care.

Consequently, the two-bed apartment had patients from Parkland in one bedroom, the Dallas County Health and Human Services (DCHHS) in another bedroom, and primary care physicians in a third room. Additionally, there was no electronic documentation and thus, paperwork could be handed from one person to the other. The clinic was extremely efficient, and highly successful.

Unfortunately, the clinic soon ran into trouble with zoning laws in Dallas, which imposed regulations around providing care in a multi-family zoned apartment. Additionally, DCHHS and Parkland broke apart. Clinical services consequently moved to the Vickery Health Center, another COPC clinic, while DCHHS moved to a building in Garland, TX. With the advent of electronic records, transfer of care was seamless, and refugees were seen regularly. This center grew and eventually became the Parkland Refugee Clinic. Dr. Rasbridge now works from his office at the Hatcher Center, a relic of the origins of the program at the East Dallas Clinic.

Despite his immense progress in advocating for and promoting refugee health, Dr. Rasbridge said there is always room for more. Particularly, he noted that the program focuses on giving refugees a "head start" into accessing care with a primary care provider at Parkland's COPC within their first year of resettlement. Refugees often come with malnourishment issues (particularly iron-deficiency anemia), orthopedic trauma, tropical infectious disease (malaria, Schistosomiasis, etc.) as well diabetes and hypertension, which he noted have been increasing in recent years. Many of these refugees stay with Parkland, with over 4,000 patient visits across the Parkland ambulatory system. This shows the accomplishment of the COPC system's goals in addressing patients' health issues before they become an emergency medical condition.

Now, Dr. Rasbridge's team includes staff members that were, themselves, refugees to serve as cultural liaisons who can educate physicians about refugees' experiences and medical beliefs, as well as counsel refugees on approaching healthcare in the US.

Pictured: (left) Dr. Lance Rasbrdige, (right) Congolese refugee receiving Covid vaccine in early months of pandemic, at an event organized in part by Parkland Refugee Outreach (credits: Jheison Romain, Dallas County)

An Interview with Dr. Rodriguez-Baez

By Sofia Babool

Can you tell me about a global health experience that was especially meaningful to you?

Some of my trips were focused more on education; others I conducted were with pediatric gastroenterologists around the nation, mostly in Latin America. This one was basically a medical mission trip that I did in 2009/2010. I always wanted to serve others and help. Since I was a kid, I used to watch TV, and I'd see how people were going to other countries to help. So there was a pediatric cardiologist, now almost retired, his name was David Fixler. He was going to an Episcopal church in Dallas called St. Luke; they started organizing a mission trip each year that was divided into four major components: medical treatment, dental treatment, construction, and education. They started a program where they would partner with a church in Honduras. Through this program, we would meet with the doctors there and provide medication and continuity of care. We started going once a year. At the same time, there was another group that would go six months later from another church with a similar concept, and we'd sometimes see those patients as well. I have seen those patients multiple times but sometimes I'm the only provider that sees them. Most of the diseases that we'd see are pretty much similar to other places, such as diabetes, high blood pressure and gastritis; but there are also a lot of muscular problems because they have to carry big containers of water in the scorching heat. It was a pretty wide range!

Do you think that all these experiences have changed how you practice medicine in the US?

I think it's helped me understand the world better; it's helped me understand that we are all humans and that we all have the same needs, but we don't have all the same resources. How blessed we are in an institution in the United States where we have so many resources! It has helped me be more compassionate, and to listen more to people. What we call here "determinants of health," for them, is perhaps not that they don't want to take their medications, but perhaps the fact that they have to decide whether to buy food or take their medication. I think that has certainly changed me; I always say it's not what I give to them when I go there, but rather what I get back.

When it comes to cultural competency, what are some pieces of advice that you have for how medical students can start building that cultural competency from now?

We are all different. We speak different languages, and we have different beliefs. If you're going to do a mission trip, study where you're going to go before you go there. Spanish is my first language and there are a lot of cultural similarities between where I grew up in Puerto Rico and Honduras, but there are certain things that are unique for the country. So I remember the very first time I wanted to learn about their food, I compared what they ate as Latinos, and found similarities with what I used to eat at home! I also tried to better understand their beliefs as well. So my advice to students is regardless of where you go, take your time to study that country, and understand the things that are going to help you provide better care.

What does the word migration mean to you?

Migration to me is evolution or growth. I would say that growth is expanding ourselves in different domains; it could be moving to a different place, or it could also be expanding what we can do for others, such as traveling abroad for a mission trip.

Many people have biases when they walk into international countries. How can we as medical students be conscious of that bias and make sure that we are providing everyone with the same treatment?

That's an important question! I think the key is to not judge. Your job is to ask what's going on, why it's happening and how you can help. Maybe a family can't afford to shower or eat. I mean, you don't have to have cancer to feel that you want to help somebody that has cancer; it's just about understanding and listening to some of those patients that I was seeing. The first step is to not judge.

Sofia Babool is a second-year medical student at UT Southwestern. She was born and raised in Dallas, Texas! Her passions include global health policy and menstruation equity, leading her to community schools in Kenya and Pakistan. In her free time, she enjoys trying out new coffee shops, playing tennis, and watching Bollywood movies.

How to Get Involved Locally

Community Wide Programs

Catholic Charities Dallas: Organizes donations, tracks inventory, assists with job readiness, SNAP/Medicaid applications, school enrollment, financial guidance, and interpretation services. Also provides administrative support and client mentoring.

International Rescue Committee: Supports refugees, asylees, and immigrants by helping them rebuild their lives in the U.S., with a focus on integration and community involvement.

Dallas Refugee Project: Promotes empathy, respect, and understanding by supporting student learning through community involvement.

MARUF Dallas: Assists refugees and individuals in need with job placement, food security, rental assistance, and financial management. Distributes Zakat funds to qualifying families.

Dallas Climate Action: Encourages involvement in environmental initiatives like CECAP implementation and offers resources for community engagement.

Habitat for Humanity: Provides opportunities to build affordable homes and contribute to community well-being through various volunteer roles.

Islamic Circle of North America (ICNA): Focuses on education, personal/spiritual development, and adhering to Islamic values within diverse communities.

Refugee Services of Texas (RST): Assists refugees and vulnerable populations with resettlement, case management, and employment services across multiple Texas locations.

World Relief Texas: Partners with churches to support refugees and immigrants with resettlement, case management, financial assistance, and English classes.

DFW Refugee Outreach Services: Bridges gaps in refugee services by providing mentorship programs and fulfilling basic survival needs.

UTSW Specific Programs

Patient Navigator Program (PNP): Established in 2020 by over 40 medical students in Dallas to improve the health of the homeless through a client-centered approach. In 2024, the Refugee Navigator Program (RNP) will launch, focusing on connecting refugees with resources, including a health fair to improve access to care.

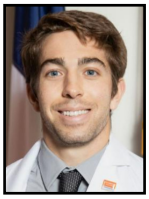
UTSW Free Clinics: A collaboration between UT Southwestern and community organizations to run student-led clinics offering public health services to underserved populations. Since 2006, the initiative has grown to five sites, involving over 883 students across various disciplines.

Home & Abroad: We'd love to hear your thoughts, read your stories, and see your vision, both at home and abroad.

Scan the QR code to reach our website, and contact any member of this year's team to learn more!

Mayuri Vaish
Editors-In-Chief

Sofia Babool
Editors-In-Chief



Benji Popokh
Graphic Design

Koshma Eswaramoorthy
Global Health Liaison