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Immigration as a structural determinant of health: embodying clinical competence for treating im/migrant patients

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SCHOOL OF MEDICINE

Thesis

**IMMIGRATION AS A STRUCTURAL DETERMINANT OF HEALTH:
EMBODYING CLINICAL COMPETENCE FOR
TREATING IM/MIGRANT PATIENTS**

by

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DEDICATION

To all the im/migrants who have moved to the United States.

Our country is a better place because of it.

ACKNOWLEDGMENTS

I would like to acknowledge the providers and patients who gave their time to this project. To you, I am forever grateful. Second, I would like to acknowledge my cohort members. I could not have managed this work without you. Third, I would like to thank my family. You are my constant pillar of support, whether you know it or not. Last, I would like to acknowledge my committee members Dr. Linda Barnes, Dr. Lance Laird, and Dr. Robert Marlin, as well as my supporters from Boston Medical Center, Dr. Sarah Kimball, Claire Oppenheim, MPH and Houda Chergui, MPH. I will forever cherish your unwavering guidance and belief in me.

**IMMIGRATION AS A STRUCTURAL DETERMINANT OF HEALTH:
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TREATING IM/MIGRANT PATIENTS**

JASON MATTHEW HYMAN

ABSTRACT

The aim of this thesis is to argue what it means to embody clinical competence for treating im/migrant patients. Im/migrants are a distinct yet heterogeneous patient population. They come to the U.S. for a variety of reasons, with a great diversity of backgrounds, upbringings, experiences, and ways of life. Considering the structural violence and push and pull factors directly connected to reasons for im/migration and experiences of distress upon settlement in the U.S., the central framework of this thesis is im/migration as a structural determinant of health. The operations of social structures, through policy, law enforcement, and discriminatory belief systems, make im/migrants structurally vulnerable. When healthcare providers treat im/migrant patients from a structurally informed approach to care, the context of these patients' needs becomes more apparent and the likelihood of positive health outcomes increases. Central to this structural approach, as I explain, is understanding how to best communicate with, gain the trust of, and provide effective social interventions for im/migrant patients relative to the operations of violent social structures. Im/migrant status truly is a determinant of health in its own right, and accordingly, care for im/migrant patients is also a specialized clinical realm with specific skills and competencies. As I argue, healthcare providers can only attain—embody—the competence for treating im/migrants through an awareness of

how social structures affect these patients' lives and modifies the delivery of care.

PREFACE

My Time at the International Rescue Committee, Tucson

As a public health undergraduate at the University of Arizona, I conducted my senior fieldwork as a health and medical advocacy intern at the International Rescue Committee (IRC) Tucson, a refugee resettlement agency. Part of my job was to accompany and advocate for refugees at their medical appointments, both for initial medical screenings and for continuing medical care. I worked with individuals from all walks of life and who came from all parts of the globe. The clients were exceptionally diverse, and I saw firsthand, every day, how healthcare providers in the U.S. struggle to comprehend the role of culture and the effects of structural violence in the lives of patients. Perspective is everything, and I found that the clients' upbringings and social ecology had an enormous influence for them. The languages they spoke, the religions they practiced, the jobs they had, the foods they ate, the songs they sang, the homes they lived in, the clothes they wore, all had their own role shaping healing and how my clients experienced the world and coped with illness. This was simply too much for many providers—a burning out and loss of fire to heal. For me, this created a spark. A new direction of interest presented itself.

There are two experiences from my time as an employee at the IRC ingrained in my memory, one *positive* and one *negative*, that pushed me down the path to commit to my academic work in im/migrant health, and more generally, health disparities.

Memory 1, August 2017: The Positive

This story is about an East-African refugee woman whom I have named Julia. She had no kids, lived with her brother, and was, and likely still is, blind. My supervisor assigned me to transport and accompany her to her primary care establishment appointment—Julia’s first appointment since her initial refugee medical exam upon arriving in the U.S.

It’s my first day in the field and knowing Julia is blind makes me even more nervous about starting my first actual day on the job. I arrive at her residential complex, a small apartment community of four two-story buildings set in a square that forms a courtyard in the middle. The courtyard has overgrown grass and weeds abound, and with the front doors and windows of individual apartments facing out to the courtyard, I hear the sounds of children and televisions at play as I walk to Julia’s apartment. I knock on the door, and after a brief wait, I meet her for the first time. She is a tall woman dressed in traditional East-African dress and headwear, and she has eyes that, even though can’t produce sight, still seem to analyze who I am. I introduce myself, who I work for, and why I am at her doorstep. She quickly remembers the reminder call for her appointment I made the day prior, and she kindly invites me into her home.

I enter, and I remind Julia of the appointment time. She acknowledges, and despite her lack of sight, moves about her apartment, finds her purse, and puts on her shoes with unexpected agility. The only item she has trouble finding, ironically, is her walking stick. After I notice it sitting against the wall behind the open front door, we depart. I take hold of Julia’s left hand to help guide her, while she holds the walking stick in her right. I feel the strength emanating from her hand into mine; I feel her kindness and desire to trust, but I also feel her weariness and her angst. She has a past more harrowing than most, and she is about to enter the car of someone who is pretty much a stranger.

We arrive at the doctor’s office after a 15-minute, silent ridden drive. As much as I want to talk, the language barrier makes this impossible. So, we both make due sitting in our own thoughts. I help Julia out of the car, I take hold of her hand, and we walk into the clinic. I assist her with check-in, a process I’m sure would feel impossible without assistance due to her lack of vision, language barriers, and unfamiliarity with the U.S. health system and organization of medical clinics. We successfully check-in, and the staff instructs us to wait at the far end of a

hallway. As we walk down the freshly waxed corridor, it's eerily silent. The sounds of mouse-clicks, keyboards, and shoe-squeaks softly echo around, and the unforgettable sterile smell of the clinic pulsates the nostrils. If I were blind, this walk, with the highly clinical stimuli around us, would feel daunting.

After about a ten-minute wait, the clinic calls Julia's name. We slowly make our way into the clinical area behind a pair of large double doors. The medical assistant (MA) asks Julia how she is doing. Julia does not respond, and I notify the MA that she requires linguistic interpretation. The MA acknowledges, and we continue our way to the vitals station. Julia seems familiar with this part of the medical encounter. She takes off her shoes and steps onto the scale without instruction, and she even offers to roll up her sleeve for the blood pressure cuff. The MA collects Julia's vitals, and we follow the MA to the exam room. Without further reminder, the MA takes out a cordless phone, calls an interpreter line, puts the phone on speaker, and reaches an interpreter as if second nature. The MA explains who they are to the interpreter, that this is a medical appointment, and that the doctor would be in shortly. The interpreter confirms on the line, and the MA leaves the exam room. Again, we wait.

Within a few minutes, the doctor enters the exam room. They walk in, sit down, grab the interpreter phone, and ask Julia, again, how she is doing. The conversation flows naturally, and the doctor appears at ease conversing through the phone interpreter. The doctor makes Julia feel comfortable, and they are kind, gentle, patient, and understanding. The appointment does not feel rushed, and Julia appears to have all of her concerns discussed without hurry or apprehension. The doctor has a way of communicating that goes beyond interpretation know-how; they are open to listening to Julia's thoughts, perspectives, and preferences. They ask for her informed consent before any physical examinations and make certain she understands her care plan moving forward. There is no judgement. The doctor is hesitant to prescribe or order tests if not absolutely necessary. The only thing Julia wants is some skin cream she received at her refugee medical exam reordered to the pharmacy, to which the doctor is happy to oblige.

The doctor and Julia finish up the appointment, and the doctor ensures with Julia that she does not have more questions or concerns before hanging up the interpreter phone. We leave the room, schedule a follow-up appointment (where I point to a calendar to confirm a date and time with Julia), and we make our way out of the clinic. Holding her hand to guide—as we walk back down the long, sterile corridor—Julia squeezes my hand three times and whispers to me, “God bless you. God bless you.”

Julia was truly grateful—for what specifically, I cannot say for certain. All I know is that I must have made seeing the doctor less stressful and less scary. I helped ease the process of getting to the doctor, checking into the clinic, and seeing the provider. Was all of this I did as meaningful as the doctor actually delivering care that was compassionate and patient-centered? I think not. But Julia gave me credit, because for her, I made it happen. Perhaps, all the doctor did was their job.

From my perspective, the notion of social stress became more clear, and as did the concept of providing medical care in a way that best suits im/migrants. At that point, social stress, social determinants of health, and social ecology became real—these things mattered in the life of Julia, and therefore, so, too, in the clinical encounter. Yes, at the end of the day, the care providers deliver matters (that is the point of this thesis). But developing competencies and practices for care means nothing if patients do not get to the doctor, know how healthcare in the U.S. works, or if the doctor does not understand the social factors at play in a patient's life. On this day, this never felt more correct. I helped Julia overcome the impediments to care she faces, and her gratefulness, in my eyes, exemplifies how strong these barriers and stressors are in the lives of im/migrant patients who frequently live on the margins. It was a stark realization that alleviating structurally derived stress, in all its forms, is just as meaningful as the clinical.

I felt proud to help mitigate a potential source of stress in Julia's life. It was, frankly, the first genuinely meaningful moment of my life. I felt a spark in my heart, and I decided from that point forth to commit my academic career to refugee and im/migrant health, and overall, health disparities caused by forces of social stratification and

marginalization. Further, seeing Julia's provider deliver care in such a way that correlated with the needs of im/migrant patients founded my interest in care delivery for this patient population. I never saw care delivered in such a way. The gentleness, the open-mindedness, the compassion, and the humanity of this doctor's practice was striking. I became captivated by the notion that there is a specialized form of providing care for im/migrant patients.

Memory 2, May 2018: The Negative

This second memory is a negative memory, but an important one at that. This was also a female refugee patient from East-Africa whom I have named Rhonda. She was a middle-aged adult with four kids ages two through fourteen.

A victim of military conflict, torture, and domestic abuse, Rhonda and her kids live in a shelter. Experiencing some clotting issues, her primary care doctor refers her to a hematologist. As her case manager, I accompany Rhonda to multiple appointments. The hematologist diagnoses Rhonda with a clotting disorder and explains that she will require three transfusion sessions with an IV medication. Rhonda, after careful explanation by her provider of the disease, medication, and support they would provide, eventually agrees to the sessions. But the clinic first conducts a pregnancy test. Rhonda insists she is not pregnant, but complies. The results state otherwise, confirming she is in fact pregnant. The hematologist approves the treatment regardless, but with precautions and monitoring. Rhonda emotionally processes her pregnancy, and she decides not to tell her boyfriend.

After four weeks, Rhonda completes two transfusion sessions. I help establish her with an OB/GYN, and her initial ultrasound is normal. Two days after this ultrasound I receive a call from my supervisor who heads my program at the International Rescue Committee. Rhonda reported to her she was experiencing a significant amount of vaginal bleeding, and I am asked to call her. I call Rhonda, wasting no time to include an interpreter. All I can make out over the rumbling is the word "blood." I pick her up and take her to the emergency department. We arrive to a moderately crowded waiting room, and I help Rhonda sign-in and explain to the nurse at reception the reason for her visit. The

emergency department receptionist, with her tired eyes, looks at us both, and she tells us to wait. After about twenty-five minutes, the staff calls Rhonda to triage.

We walk through the large double doors separating the waiting room from the emergency department. We continue down a hallway and into a small, darkly lit room. At the far end of the room sits the triage nurse practitioner (NP) and a trainee. As we entered the room and sit down, the NP continues to sit with their back to us and type on the computer. They hardly recognize our presence. After thirty seconds, they spin around and ask the usual, "What problem can I help you with today?" Rhonda struggles to articulate the problem in English, and I kindly add that she would require a linguistic interpreter to explain. Seemingly unprepared, the NP asks the trainee to run out and inquire with the attending physician about an interpreter. The trainee scurries out and returns in a few minutes. They open up a cabinet and take out an old, wired phone with two handsets. They plug the phone into the telephone line and power supply, and they follow the instructions for interpretation taped onto the phone. The NP hands one handset to Rhonda while they take the other. The NP goes through the instructions, requests a linguistic interpreter, and waits. I see in the NP's eyes they are worried about time and the length of Rhonda's triage session. I become concerned they will rush Rhonda and not give her enough opportunity to explain her situation.

The NP eventually reaches an interpreter, and Rhonda details the reason for her visit to the emergency room. The NP records her statements and goes into Rhonda's electronic medical records. They see that Rhonda received a normal ultrasound just a few days prior and because so, the NP says adamantly that nothing should be done. They recommend that Rhonda go home, but Rhonda insists they are wrong. She explains that there was "a lot of blood" and expresses her worry as best she can, but the NP continues to state that there is likely nothing wrong because of the unremarkable ultrasound taken within the past seventy-two hours. The NP does not conduct a pelvic exam nor refer for one. Rhonda continues to disagree, and I step in to advocate. Eventually, and mainly because of time and the NP's acceptance that Rhonda would not leave the room unless the hospital staff treated her, the NP assigns her a bed and orders a pelvic ultrasound. They direct us to the waiting room until a bed is ready.

After about an hour, a bed becomes available for Rhonda. We get up, pass back through the large double doors, and follow the orderly. We get to the room and a nurse instructs Rhonda to change into the hospital gown neatly folded on the bed. I leave the room to give Rhonda privacy. After ten minutes, Rhonda's emergency care provider, a new nurse practitioner, comes into the room to introduce themselves and discuss the reason for Rhonda's visit. Again, the provider is ill-prepared to use

linguistic interpretation and it takes some time to connect the phone and reach an interpreter. Rhonda discusses her concerns with the new NP, who I could tell was uncomfortable using the interpreter phone. They appear flustered, stuttering and over extending their sentences. But Rhonda and the NP finish their discussion without too much hiccup. After thirty more minutes, a few nurses arrive to take Rhonda for her ultrasound. I accompany Rhonda, and I leave her only once the ultrasound technician begins the imaging. I wait in her room, and she arrives after about twenty-five minutes. Together, we wait for another hour and a half.

The NP returns, looks at us both, and proceeds to the interpreter phone. They hand Rhonda one headset, while they take hold of the other. We all sit in silence as we wait to get connected to an interpreter. Rhonda and I turn towards each other and meet the other's gaze. It is as if we could both already tell the news would be grave. Shortly, an interpreter comes on the line, and the NP proceeds to speak. Without hesitation and without emotional inflection they say, "The ultrasound shows that you've had a miscarriage. We will do a pelvic exam to make sure. I am sorry. Do you have any questions?"

Rhonda is outwardly in shock, and she answers with silence to whether she has any questions. The NP, too, has nothing more to say. I ask for the interpreter phone and a counselor of some sort. The NP acknowledges my requests and leaves the room. I am left alone with Rhonda. There I am, a twenty-two-year-old man with no kids of my own, left to console and support this refugee woman—a survivor of torture—after she is told she lost her unborn child. I am out of my depth, and it feels like the staff at the hospital are too.

The counselor never arrives, and Rhonda asks me if we could leave and for me to drive her home. I comply. As Rhonda walks from my car to the gate of her residential complex, I can tell that this woman is not just disconsolate because of the loss of her unborn child, but that this woman is tired—tired because of the seemingly endless struggle for peace, and that even when she seeks help at the hospital, new problems often appear and the old frequently persist.

Neither the first nor second nurse practitioner tried to console Rhonda, offer support, or acknowledge her suffering. To them, she was just a patient and this was just another medical event. They did not seek to consider Rhonda's religious faith, her history of trauma, the four kids she already had, or even the language she spoke. The care and services offered throughout this clinical scene displayed enormous gaps in providing care

for im/migrants, and in particular, refugees. Further, the frustration I felt was that much stronger knowing that delivering effectual care for im/migrants is possible, per the experience I first described. Instead, for this event, I alone was left to help pick up the initial pieces. To remind Rhonda she was an excellent mother and a resilient woman—a woman who had overcome so much more.

I felt it important to share these two experiences because they form part of the foundation for my interest in refugee and im/migrant health (i.e. why I am invested in writing this thesis). These two experiences, which bring perspectives of the *positive* and *negative*, shaped my initial observations of the social patterns regarding refugee and im/migrant health and the disparities in the quality of care this patient population receives. I saw how delivering care that is kind, patient, compassionate, and trauma-informed brings positive results, but that this can only go so far if remedies do not allay social barriers to care and social stressors in a patient's life (Bourgois et al. 2017; Westerhaus et al. 2015). Moreover, the empathetic and considerate care I saw in my first patient advocate experience is not the norm and is more akin to the second experience I described—encounters that im/migrants find frustrating, stressful, unhelpful, and even harmful (Aparicio 2008; Garrett et al. 2008; Mangrio and Sjögren Forss 2017; Omenka, Watson, and Hendrie 2020; Suurmond et al. 2011).

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LIST OF ABBREVIATIONS

ACGME.....	Accreditation Council for Graduate Medical Education
BCRHHR	Boston Center for Refugee Health and Human Rights
BMC.....	Boston Medical Center
CME.....	Continuing Medical Education
ICE.....	Immigration and Customs Enforcement
IRHC	Immigrant & Refugee Health Center
PCMH	Patient-Centered Medical Home
SDH.....	Social Determinant(s) of Health
USCIS.....	United States Customs and Immigration Services

LIST OF KEY TERMS

Asylum Seeker:

According to United Customs and Immigration Services (USCIS) and U.S. law, an asylum seeker is defined as someone who: “1) meets the definition of refugee” (below; 2nd, 3rd, & 4th criteria); “2) is already in the U.S.; and 3) seeking admission at a port of entry” (USCIS 2015). There are two ways to apply for asylum: 1) Affirmative Asylum & 2) Defensive Asylum (for more information, see: <https://www.americanimmigrationcouncil.org/research/asylum-united-states>).

Im/migrant:

An inclusive term that incorporates the diverse reasons for moving across international borders. Migration is not simply the intent for permanent settlement in another country (i.e. immigration and emigration), there are other labels dependent on the mode of migration, colloquial language, and political terminology, such as *refugee*, *asylum seeker*, *unauthorized*, *illegal*, *undocumented*, *migrant farmer worker*, *victims of trafficking*, *international students*, *specialty occupation visa holders*, and more.

Im/migrant accounts for and is inclusive of all peoples who move across international boundaries regardless of how they perceive their migration trajectory (Castañeda 2010).

Lifeworld:

The lifeworld is the everyday world of our individual perception. The fluid compounding of our upbringing, experiences, learnings, and relationships that coalesce to form our individual values, beliefs, morals, practices, and life within the social worlds we encounter. Through our

experiences and exposure to worldly phenomena, we give meaning to ‘things’ and construct our own individual perceptions of reality and being. “It [the lifeworld] is the individual approach of world and life, a natural attitude which shapes approaches to our daily living and depends on the historical, cultural and social contexts humans are involved in. Individuals perceive things ‘in–the–world’ in different ways” (Hörberg et al. 2019).

Neoliberalism:

An economic and political belief system which strives for minimalist state intervention, reduced regulation, and free-market capitalism. Government is seen to be the problem, an actor that checks civil liberties and interferes with the market through public welfare systems. In theory, the goal is a withdrawal of the welfare state where individuals are left to fend for themselves (Lobao et al. 2018). “A loosely demarcated set of political beliefs which most prominently and prototypically include the conviction that the only legitimate purpose of the state is to safeguard individual liberty, understood as a sort of mercantile liberty for individuals and corporations. This conviction usually issues, in turn, in a belief that the state ought to be minimal or at least drastically reduced in strength and size, and that any transgression by the state beyond its sole legitimate *raison d’etre* (i.e. purpose or function) is unacceptable” (Thorsen 2010).

Otherness and

The Other:

The dividing nature of dominant groups considering less dominant groups a threatening Other who must be degraded

and neutralized in an effort to protect societal, cultural, and economic ideals. Less dominant groups, The Other, possess traits of Otherness which dominant groups perceive as a menace that need either be kept separate or forcibly culturally assimilated. “Otherness is due less to the difference of The Other than to the point of view and the discourse of the person who perceives the Other as such. Opposing Us, the Self, and Them, the Other, is to choose a criterion that allows humanity to be divided into two groups: one that embodies the norm and whose identity is valued and another that is defined by its faults, devalued and susceptible to discrimination. Only dominant groups (such as Westerners in the time of colonization) are in a position to impose their categories in the matter. By stigmatizing them as Others, Barbarians, Savages or People of Color, they relegate the peoples that they could dominate or exterminate to the margin of humanity” (Staszak 2009).

Patient-Centered Care:

Clinical care that puts the patient first, considers their cultural and social needs, and includes them in all matters of care delivery. Patients are constantly involved in their care, and providers take the time to ask about and/or explain all clinical matters, from procedures, barriers to care, adhering to prescriptions, or otherwise. Care is not limited to the physical body, but all matters of the patient’s wellbeing are addressed, such as the spiritual and emotional aspects of health, healing, and illness. “Care provision that is consistent with the values, needs, and desires of patients and is achieved when clinicians involve patients in healthcare

discussions and decisions. The Patient Centered Clinical Method identifies that patient-centeredness is achieved in part by understanding patients' experiences with illness and disease as well as understanding patients holistically [...] the three main objectives of patient-centered care provision should include effective communication, partnership, and health promotion" (Constand et al. 2014).

Refugee:

According to United Customs and Immigration Services (USCIS) and U.S. law, a refugee is defined as someone who: "1) is located outside of the United States; 2) of special humanitarian concern to the United States; 3) has demonstrated that they were persecuted or fear persecution due to race, religion, nationality, political opinion, or membership in a particular social group; and 4) is not firmly resettled in another country" (USCIS 2020). As the United Nations and United Nations High Commissioner for Refugees (UNHCR) defines them, "refugees are people who have fled war, violence, conflict or persecution and have crossed an international border to find safety in another country [...] someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (UNHCR 2021; UN General Assembly 1951).

Social Determinants
of Health:

The social and environmental conditions which affect health. Health and disease is not simply about the body, but

where the body exists and what the body is exposed to. “The non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life” (World Health Organization 2021). Examples, as listed by the WHO, include: Income and social protection; Education; Unemployment and job insecurity; Working life conditions; Food insecurity; Housing, basic amenities and the environment; Early childhood development; Social inclusion and non-discrimination; Structural conflict; and Access to affordable health services of decent quality.

Social Structures:

The socially, culturally, and economically informed societal structures that organize and arrange societies. On a macro scale, they are the large institutional systems and establishments which lay the foundation of society, including government itself, the judicial system, penal system, housing system, educational system, etc. But social structures also relate to more ambiguous social systems and beliefs such as racism, xenophobia, feminism, and liberalism which may both reinforce and respond to larger social arrangements. At the meso and micro levels, there are also the cultural, communal, and personal frameworks which structure human life, such as religion and places of worship, community centers, sports teams, family, hobbies, and anything else one may include the structure of their social and cultural life. “Social relations and arrangements—economic, political, legal, religious, or

cultural—that shape how individuals and groups interact within a social system. These include broad-scale cultural and political-economic structures such as caste, patriarchy, slavery, apartheid, colonialism, and neoliberalism, as well as poverty and discrimination by race, ethnicity, gender, sexual orientation, and im/migrant-refugee status” (Rylko-Bauer and Farmer 2016, p. 47).

Structural Competency:

A healthcare provider’s ability to understand, identify, and grapple with the unjust and consequential effects of structural violence and socioeconomic inequality, both within the life of individual patients and the operational arrangements of inequitable social structures. At the most basic, it is about healthcare providers understanding how and why social structures cause undue harm to patients, and then strategizing solutions that alleviate suffering and create equitable change at micro and macro levels. “The capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures; and highlights the concepts of structural violence and the naturalization of inequality” (Neff et al. 2020, p. 2).

Structural Determinants
of Health:

Whereas social determinants of health refer to how the socioenvironmental contexts in which people live, work, and play affect health, structural determinants of health are the underlying reason for why inequitable sociostructural contexts and operations exist. As ingrained in unjust government policies and unchecked free-market capitalism,

the organization and arrangement of social structures throughout U.S. society inform why social inequality and social determinants of health exist and generate illness/health for discrete populations. “The ‘root causes’ of health inequities. They shape the quality of the social determinants of health experienced by people in their neighborhoods and communities, including the governing process, economic and social policies that affect pay, working conditions, housing, and education. They affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual identity, or other socially defined group of people” (Illinois Department of Public Health 2021; World Health Organization 2010).

Structural Violence:

The outcome of which peoples are harmed by social structures, systems, and belief systems. Whether intentional or not, social structures proliferate violence, adversity, and strife in people’s lives, making upwards mobility and survival more difficult for some than others. “The avoidable limitations that society places on groups of people that constrain them from meeting their basic needs and achieving the quality of life that would otherwise be possible. These limitations, which can be political, economic, religious, cultural, or legal in nature, usually originate in institutions that exercise power over particular subjects. Because these limitations are embedded in social structures that operate normatively, people tend to overlook

them as nothing more than ordinary difficulties that they encounter in the course of their daily lives” (Lee 2019, p. 123).

Structural Vulnerability:

The relative vulnerability to structural violence for minorities. In terms social hierarchy, hegemony, and the operations of structural violence, certain groups are made more vulnerable to the forces of social inequity and illness than others. “An individual's or a population groups' condition of being at risk for negative health outcomes through their interface with socioeconomic, political and cultural/normative hierarchies. Patients are structurally vulnerable when their location in their society's multiple overlapping and mutually reinforcing power hierarchies (e.g. socioeconomic, racial, cultural) and institutional and policy-level statuses (e.g. immigration status, labor force participation) constrain their ability to access healthcare and pursue healthy lifestyles” (Bourgois et al. 2017, p. 17).

CHAPTER ONE: INTRODUCTION

I met Shauna on a brisk March morning at Boston Medical Center. A provider had just referred her to the Core Competencies study as a patient participant, and I was excited to have my fourth patient interview (unbeknownst to me at the time that this would be my last in-person interview because of COVID-19). Sitting on a chair in the lobby of the medical building, she is a small woman, maybe just a smidge over five feet tall. Round glasses cover her face and she is bundled up in an oversized coat, scarf, and beanie to keep warm. Not one hundred percent sure this was her, I ask, “Excuse me, would you happen to be Shauna?” She confirms. I introduce myself and Shauna pops out of the chair and shakes my hand. I ask her how she is doing this morning as we make our way to the elevator. “I’m doing fine,” she says. I can hear a slight shake in her voice and I get the sense she is nervous. We ride up to our floor, and she follows me into the clinic where we will conduct the interview.

The interview room is a small, private space within a research clinic on the Boston Medical Center (BMC) campus. The research personnel consider it a qualitative interview room, but it is really just a spare office. A desk and computer sit against one wall, and in the extra space stands a foldable, plastic-top table. There is a folding chair at both ends, and Shauna and I take a seat. We start the interview process and begin talking about her journey as an im/migrant in the United States.

Shauna tells me she came to Boston from the Caribbean as an unauthorized im/migrant seeking better socioeconomic opportunities. Upon arriving and living in the

U.S., rather than fulfilling the iconic American dream, she ran into further socioeconomic hardships and ended up homeless, a common result for im/migrants in the U.S. (Galley 2018; Tsai and Gu 2019). In the meantime, she tells me that medical issues piled up and rather than access subsidized care through Chapter 58, which established health coverage provisions regardless of citizenship status in Massachusetts, she sought care under a false identity.

***Shauna:** A friend offered me, to let me use their name to go to the doctors. And that, I went there, and I was using that name for a long time. I went to the hospital, and I was admitted to the hospital as somebody else. And that is [emphasizes] very scary. It's very scary to be admitted in the hospital as somebody else. I'm there, and my high blood pressure keeps going up, up. And they didn't know why, but I know why. Cause I was in the hospital as somebody else.*

The question, then, is why Shauna decided not to seek care under her own identity. One reason could be she was simply unaware of Chapter 58 and the healthcare provisions it made available to unauthorized im/migrants. Indeed, Joseph (2018) notes that a lack of information is a major reason im/migrants of all statuses do not apply for the public benefits or access the services they are eligible for. However, this is not what Shauna says. She tells me the reason she sought care under a false identity was that she feared being discovered by ICE (U.S. Immigration and Customs Enforcement).

***Shauna:** We [unauthorized im/migrants] are very fearful when we come to this country. Even to take the train, or bus. It's scary. Like, you have to keep looking behind you. I went through that for about 10 years. Scared. Not, don't wanna go to the hospital [...] I remember one time I was on the train, and I was just sitting there looking behind me and in front of me, and I just think everyone is Immigration (ICE) on the train. It's a very tough feeling [...] It makes you go crazy.*

Anti-im/migrant sentiments and policies create fear among im/migrants, and the thought of being discovered and deported resulted in Shauna deciding to forgo applying for and accessing eligible services, and further, even a sense of worry when taking the train. While eligible to receive subsidized care regardless of her unauthorized status, government policies that evoke im/migrant fear disempowered Shauna and caused her constant concern. This resulted in the precarious situation of her accessing care under a false identity, which also corresponded with a rising blood pressure providers could not figure out. Not only was her health at risk because of hypertension and socioeconomic stressors, but this also hindered her providers' abilities to deliver appropriate care while she was in the hospital. Such examples and stories are emblematic of the unique problems im/migrant patients and their providers deal with on a daily basis.

Purpose

What does it mean to provide excellent high-quality care for im/migrant patients?
What does it mean for a healthcare provider to embody competence for treating im/migrant patients? These are the two primary questions I seek to answer in this thesis. Im/migrants are a diverse group of U.S. residents. They come from all over the world and hold infinite experiences, beliefs, perspectives, and values relative to daily life and health. Further, the experiences of im/migrants are highly structurally informed—there are social structures, policies, laws, and belief systems that make life harder for them. Im/migrating is more than the adjustment to new surroundings and cultures across international borders. Castañeda et al. (2015, p. 386) argue “it is also a complex and often protracted process of negotiation with social structural, political, and economic forces [...] To make

substantive improvements in health outcomes, immigration must be understood as a key social determinant of health in its own right.”

I argue that the delivery of high quality care for im/migrant patients flows from understanding im/migrant health through a structural lens. True clinical competency for treating im/migrant patients comes from an engagement with and understanding of the structural factors—“social and economic policies; laws regulating the distribution of health and social resources; and social stratification based on race, ethnicity, religious affiliation, immigration status, ability, gender identity, sexual orientation”(Neff et al. 2020, p. 2)—that affect and relate to this patient population’s health. To support my argument, my intent has been to introduce the realities and share the experiences of im/migrant patients and their providers both in and outside the clinic. I consider the systemic constraints healthcare providers face, putting in conversation their clinical experiences and recommendations with that of the im/migrant patients they treat. *What are the stressors and needs of im/migrants? How do im/migrants want to be treated? What do they, as patients, recommend? What does competent care look like and consist of for this patient population?*

To help answer these questions, I conducted semi-structured qualitative and ethnographic interviews with im/migrant patients who receive care at Boston Medical Center (BMC). I asked them about their daily struggles, their healthcare experiences, and their recommendations for high-quality care delivery. Moreover, I also observed and interviewed providers—healthcare providers and immigration legal providers—who provide services to these patients in the greater Boston area. As part of a larger research

study at Boston Medical Center (BMC), a significant safety-net hospital in the heart of Boston committed to treating underprivileged populations, much of the data I present concerns refugees, asylum seekers, and unauthorized im/migrants. While BMC treats im/migrants of all backgrounds, whether rich or poor, these are prominent patient populations who receive their services. In response, BMC's Immigrant & Refugee Health Center (IRHC) developed the core competencies research project, a study aimed at determining the best practices—and more specifically the Accreditation Council for Graduate Medical Education (ACGME) core competency recommendations—for treating im/migrant patients. The end goal, subsequently, for the IRHC, is to develop an ACGME approved continuing medical education (CME) course and clinical fellowship in im/migrant and refugee health clinical practice. My thesis derives from this research project.

As such, at the core of both my thesis project and the development of the CME/fellowship curriculum is the concept of competence. *What does it mean to be a competent clinical provider for treating im/migrant patients?*

In answering this question, my thesis and the CME/fellowship differ in numerous ways, mainly in terms of the primary objective. Whereas the CME/fellowship seeks to determine specific ACGME core competencies for im/migrant and refugee clinical practice, my thesis specifies the embodied qualities of competence needed to treat im/migrant and refugee patients. I am not designing a clinical curriculum, but I am arguing what a graduate medical education curriculum in the realm of im/migrant and refugee health may include and what competence in this clinical arena may entail. In

doing, so I discuss the lived reality of im/migrant patients, illustrating aspects of patient embodiment that drive the distinct and necessary types of provider knowledge and skills to treat this patient population. I am not so much stating what healthcare providers need to know and do, but I am sharing stories and experiences from providers and patients that underpin why im/migrants and refugees may often times require discrete forms of clinical intervention, and moreover, what provider training and the embodiment of competence for treating these patients includes and looks like.

In part, however, the ACGME core competencies for continuing medical education guided my thesis research. The ACGME sets the basic criteria for what makes a *competent physician* across the U.S. biomedical system when undergoing graduate medical education (i.e. internships, residencies, and fellowships.) Therefore, because a licensed doctor must undergo post-graduate training that adheres to the core competencies established by the ACGME, my conceptual framework for data collection and analysis follows suit (this was a decision made by IRHC faculty).

Moreover, both my thesis and the CME/fellowship emphasizes how structural forces enter the lives of im/migrants and affect wellbeing and quality of life; the ways in which the historical and current political economy and sociocultural landscape of the U.S. has formed the status of im/migrant as a structural determinant of health. Specifically, the CME/fellowship course will present a clinical curriculum for training physicians in im/migrant and refugee clinical practice. In addition to detailing how to treat the diseases and bodily ailments these patients may present with, it will also train physicians to recognize, respond to, and alleviate stress and illness rooted in structural violence. My

thesis, alternatively, tells stories about how structural violence enters the lives of im/migrant patients and argues why and how embodying the clinical competence for treating im/migrant patients stems from understanding im/migration as structural (social) determinant of health.

The stories and data I present emphasize the lived experiences of the patients and providers I spoke with—that is, the lives of real persons in real bodies, living through the challenges of managing im/migrant health. The focus on embodied reality is, in medical anthropology, a sub-theme of phenomenology, a philosophical approach that studies consciousness from the first-person point of view (Smith 2018). One of the foremost scholars of this type of phenomenological thought is Maurice Merleau-Ponty, who states that embodiment is about perception and awareness as a body “which embraces and constitutes the world” as it is known.

Our embodiment brings to our perceptual experience an a priori structure whereby it presents itself to us in consciousness as experience of a world of things in space and time whose nature is independent of us. It is our ‘bodily’ intentionality which brings the possibility of meaning into our experience by ensuring that its content, the things presented in experience, are surrounded with references to the past and future, to other places and other things, to human possibilities and situations (Baldwin and Merleau-Ponty 2004, p. 10).

Embodiment is the conscious awareness of our body in space, and equally, that our “embodied actions” can consciously change over time as we gain knowledge, experience, and new perceptions (Smith 2018). For Shauna, this meant the development of an embodied hypervigilance due to violent anti-im/migrant government policies. Looking over her shoulder on the train, avoiding institutions associated with officialdom,

and using a false identity to seek care, she began to embody actions and behaviors relative to risk and safety.

For providers, it means developing the skills, traits, and expertise for treating im/migrants as they are exposed to the structural and clinical difficulties these patients face. This can arise through direct patient interactions, research, and importantly, clinical training. A critical aspect of embodying clinical competence is the transfer of knowledge from clinical leadership to residents and/or fellows. As Janette Young (2012) argues, this is a progression of “personal knowledge capital,” which “highlights the value of tacitness in the shape of know-how, insight, ideas, and emotion so they can be shared between individual knowledge workers in organizations” (Young 2012, p. 11). In medicine, this consists of more experienced providers transmitting what they know—their embodied intelligence about treating im/migrant patients—to less experienced and knowledgeable providers. But even more so, this educational transmission can flow to patients, where both seasoned and newly-minted providers pass on information—knowledge capital—to im/migrant patients so they can take control of their own health in the U.S.

While seemingly just the passage of information—or data—from provider to provider or provider to patient, such information, over time, can become embodied knowledge that affects decision making and rationality. As we encounter new experiences and gain new insights and perspectives, we change, embodying newfound stimuli that alter how we exist in our own body. Experiences alter who we are, and dynamically over time—whether temporary or permanent—also become part of who we

are, shaping our actions and being in the real world and affecting our body, mind, spirit, and soul.

Within the field of psychology, this is similar to the concept of “unconscious consciousness” (Bernet 2002), a cognitive state first described by Sigmund Freud and Edmund Husserl, where one has developed instinctive skills. As we take in new phenomena of our world, whether through conversation, observation, or otherwise, there are opportunities for human development. Embodiment is the knowing adjustment of our behaviors and actions— “bodily intentionality” —as we absorb and amass new experiences and information to the point they become second nature—embodied competence and being.

For healthcare providers, this means learning what im/migrant patients’ experience, and from there, these patients’ needs. Over time, through exposure to im/migrant patients and teachings from clinical mentors, providers can accumulate the knowledge to tacitly deliver care to im/migrant patients and combat the unjust social structures that make life difficult for them. For im/migrant patients, it means embodying fear, uncertainty, insecurity, and “unbelonging” (Bendixsen 2020) relative to violent anti-im/migrant policies, informing how and why decision in reality are made. However, it may also mean the embodiment of tenacity, fortitude, resilience, and independence as one rebuilds life. For either group, they begin to amass new skills, abilities, and awareness relative to new experiences—good or bad—and the attainment of knowledge across time, changing how one exists in and uses their body.

Moreover, the concept of embodied knowledge in medicine concerns the study of “body pedagogics” (Kelly et al. 2019), which seeks to bridge the “embodied realities of [medical] practice and the disembodied nature of medical education” (ibid, p. 967). All too often, the cognitive aspects of medical education take precedent, leaving behind a lack of bodily awareness amongst healthcare professionals who never learn why and how they have come to exist in their own body. Body pedagogics is an avenue towards interlayering the processes of learning human physiology, anatomy, and clinical assessment with that of the provider’s body and senses of embodiment.

The body is sensate, a site of knowledge production and corporeal wisdom, which is a critical yet often disregarded aspect of health professions education [...] Body pedagogics can help us to focus attention on embodiment as a central principle of health professional education that transcends the discipline-specific teaching of clinical skills. Moreover, it provides a set of conceptual foundations for an interdisciplinary practice within health professional education with implications for instructional design. Body pedagogics can also help us to make strange the habits and disregarded aspects of embodied learning and in so doing help us to consider embodiment more critically and directly in practice and education, and in the ways we research them” (Kelly et al. 2019, p. 973).

Therefore, when I say the goal of this thesis is to probe what it means to embody competence for treating im/migrant patients, I am arguing what it specifically means to exist in a body that holds an unconscious awareness of the clinical practices, needs, and forms of knowledge—“enskillment” (Ingold 1996)—required to effectively treat this patient population. The point at which a provider can ‘just do competent care’ for im/migrants without second thoughts—as embodied habit (Merleau-Ponty 1962; Moya 2014).

This habitual and enskilled “unconscious consciousness” for treating im/migrant patients, I argue, comes from mastering three key dimensions of clinical care: structural

competence; trust and communication; and interprofessional collaborative care. When a provider properly navigates im/migrant care through these three domains, informed by structural perspectives and understandings, they can embody effective practice-based competence. This lays a foundation for the development of a type of clinical *habitus*—socially influenced and embodied habits and dispositions (Bourdieu 1977; 2000)—for delivering effective, high-quality care to im/migrants. Moreover, it is my hope that this thesis will serve as a resource for improving the “bodily intentionality” of healthcare providers. To function as a reference tool for developing an embodied philosophy of im/migrant health “system-challenging praxis.” These are clinical actions and interventions that “strive to heighten rather than dissipate social action and to make permanent change in the social alignment of power” (Singer 1995, p. 90). Or, in other words, providers embodying clinical practice that accounts for and challenges the structural roots of im/migrant marginalization and implementing clinical interventions that best meet these patients’ needs in the context of their everyday lives.

Furthermore, discussion of im/migrant patient embodiment concern the concept of what Bendixsen (2020) terms as “existential displacement” and “im/migrant unbelonging,” Relative to historical and present anti-im/migrant hostility and violent deportation policies in the U.S., im/migrants may develop embodied feelings of Otherness (Staszak 2009).

Migrants’ experiences of embodied unbelonging are a consequence of a violent form of governmentality that includes specific laws, healthcare structures, and migration management rationalities [...] The narratives of their state of being in-the-world are ways through which migrants both experience and express the violence and deprivation they face (Bendixsen, p. 479).

Putting this another way, in the face of anti-im/migrant policies and social structures, im/migrants and their narratives begin to reflect and embody feelings that they do not—or should not—belong. In truth, this is certainly not the case, as im/migrants bring tremendous value to the communities they move into. The point, rather, is that im/migrants begin to perceive their “being-in-the-world” comparative to disparaging and destructive beliefs systems rooted in discriminatory values. The result can significantly affect how im/migrants live in and perceive of their own body.

Why this matters

According to the Pew Research Center, the number of im/migrants in the U.S. reached a record high of 44.8 million in the year 2018, accounting for nearly fourteen percent of the population (Pew Research Center and Budiman 2020). Coming from all over the world for a plethora of reasons, im/migrants are a large and distinct, yet highly heterogeneous, subset of the U.S. population, creating a need to understand how to best deliver such patients care and ensure their wellbeing.

Castañeda (2010) notes, “At its most basic, the very decision to migrate reflects a marginalized position in the global economy.” People do not migrate in a vacuum. There are push-pull factors that press the need to move across international borders. Depending on the factors that create this need, certain health issues arise. Refugees, after already facing persecution, may live decades in unsanitary and dangerous refugee camps. Asylum seekers may walk thousands of miles in brutal conditions to the U.S. border, only to have United States Customs and Border Protection (CBP) deny them entrance. H1-B visa recipients (specialty occupation) may have faced economic hardship and unemployment

in their home country. A seasonal, im/migrant farmworker may cross the border unauthorized, work for a few months, and then return home. There are a myriad of possible reasons and contexts for im/migration, and as such, the experiences of im/migrants and their health concerns are of the utmost clinical concern.

There must be a specialized realm of clinical and public health practice dedicated to understanding im/migrant patients' needs and how to best deliver them care. While researchers in im/migrant studies have conducted research in this area, there is still much to do and learn, and in response, this thesis further addresses the research and clinical gap that is understanding how to best deliver care to im/migrants. There are few clinical residencies committed to care instruction for treating im/migrants, and there is currently one clinical fellowship in this medical specialty, the Massachusetts General Hospital Thomas S. Durant Fellowship for Refugee Medicine (which has historically focused on humanitarian health efforts outside of North America). Furthermore, public health efforts have predominantly focused im/migrant health research in the field of global health rather than exploring the specific needs of im/migrants within U.S. borders. In short, there is a critical need for researching and implementing clinical and public health programs specifically concentrated on delivering care to and protecting the health of im/migrants in the U.S. The intent of this thesis is to support this need while simultaneously providing context, background, and narrative regarding the experiences of im/migrants and their providers. Concurrently, I also offer insight about embodied competence in the clinical specialty that is im/migrant and refugee clinical practice.

However, this thesis does not delve into the physiological and anatomical aspects of healthcare provider training, and I do not discuss how to treat disease or injury biomedically. I do not discuss topics such as antibiotic courses for infectious diseases, vaccination regimens, diabetes treatment, and methods of pharmaceutical and psychotherapeutic management of behavioral health disorders (which are all key aspects of treating im/migrant patients). Instead, I direct such inquiry to Pottie and colleagues' (2011) extensive article, *Evidence-based clinical guidelines for im/migrants and refugees*. Their document provides clinical recommendations on screening for and treating the diseases im/migrants often have. In other words, Pottie et al. outline how to treat the diseases that may affect the im/migrant patients' body. Conversely, this thesis discusses aspects beyond the body that affect health and clinical outcomes—those that deal with social and structural forces, communication, narrative, and collaboration. While not directly connected to exploring and managing human physiology, these clinical domains are integral to the provision of high-quality care and the protection of im/migrant patient well-being.

At the heart of providing competent, high-quality care to im/migrants, then, is heuristics. Learning is processual, and there is always room for providers to ask questions and reflect. The needs and backgrounds—lifeworlds—of im/migrant patients, and really all patients for that matter, are too diverse for a provider to think they have all the answers. As Swedburg (2014, p. 128) writes, “Every situation is somewhat different from all others, and this means that you quickly and instinctively have to adjust, improvise, and try something that is a bit new in order to move forward.” Without a heuristic

mindset, one that stems from the goals of humility, ingenuity, and patient-centered care, a provider cannot deliver appropriate clinical services. Heuristics, a provider's genuine curiosity to gather new information, exchange ideas, and explore the lived realities of im/migrant patients, drives excellent high-quality care. It sets a foundation for ongoing education and introspection relative to the provider's clinical abilities and what patients need—it is the essence of clinical embodiment. Seeking to constantly gain new perspectives, information, and insights about how to best deliver their im/migrant patients care and become aware of the experiences these patients undergo, heuristics can be a catalyst for attaining competence. In this thesis, I share stories and information that support the distinct heuristics required for treating im/migrants.

Chapter Outlines

The second chapter of my thesis provides background information on the health and social pressures im/migrants face. Here, I outline the sociopolitical and economic processes that marginalize im/migrants and contribute to their diminished health outcomes. I argue that the neoliberal framework of U.S. free-market economics, in tandem with systems of im/migrant labor exploitation and deservingness, puts im/migrants in a precarious relationship with the state. This, as I will also explain, becomes further complicated with the rampant spread of racism, anti-im/migrant sentiments, and unjust government policies that elicit an im/migrant fear of seeking healthcare services and undergird forces of structural violence. In addition, this chapter includes a brief discussion of the migration phases and how people of different

im/migrant categorizations experience them differently, resulting in specific health problems and needs.

The third chapter outlines my research methods. I discuss how this project came to be and how I collected and analyzed the data. Accordingly, I also shine light on how the research changed before, during, and after the SARS-CoV-2 pandemic.

My three data analysis chapters, which my participant interviews and field observations inform, follow. Chapter four, Structural Competence, further contextualizes im/migration as a structural determinant of health. I provide several im/migrant patients' stories that illustrate the structural issues of their everyday lives, particularly bringing attention to the concept of bureaucratic disenfranchisement. I follow with a discussion about social determinants of health (SDH) screeners, which I argue are an effective tool for assessing and combating im/migrant patients' structural vulnerability. Moreover, I add that SDH screeners can also be fiscally beneficial, as they help ensure reimbursement and render the roots of poor health outcomes in patient's lives (Bourgois et al. 2017). Next, I discuss the importance of eliciting the im/migration narrative, and I bring attention to the family, which every patient mentioned in some way, as a critical aspect of im/migrant resiliency.

Chapter five, Trust and Communication, describes how the unique experiences of im/migrants—particularly the loss of agency for forced migrants—creates specific distinctions on how healthcare providers approach matters of communication and trust-building. The im/migrants I spoke with often perceive healthcare services as part of the government apparatus, and because government is often at the heart of why refugees and

asylees experience trauma and/or flee their home, they think of healthcare as not to be trusted. I argue that this necessitates specific communicative practices that mitigate the reservations im/migrant patients have towards sharing information and building a relationship with providers. I then move on to discuss *clinical negotiation*— “transactions across explanatory models” (Kleinman, Eisenberg, and Good 1978)— between patients and providers relative to healthcare intervention decision-making. The im/migrant patients I met came to the U.S. with a diverse set of beliefs and values in terms of their perceptions of illness and corresponding treatment preferences. When providers and patients do not agree on how to move forward with care, it is up to providers to negotiate a shared decision with patients. Last, I introduce the notion of “the grace of small gestures,” minor yet tangible interventions such as a winter coat, pair of shoes, or gift-cards that patients said stand out to them and combat the roots of daily social stressors, such as food insecurity.

Chapter six, *Interprofessional Collaborative Care*, considers the value of collaboration in the efforts to meet the healthcare needs of im/migrant patients. Both the im/migrant patients and providers I interviewed indicated issues in housing, immigration, schools, and more, creating a need to work with and coordinate the input of professionals in many fields. Further, this chapter also discusses the different people in the patient’s life who may be involved in healthcare decision-making, such as parents, siblings, and children. To that end, I emphasize the patient as the provider’s most important collaborator, and I supplement this notion with a brief discussion of the benefits of patients working together to help heal and rebuild each other’s lives. I add that the

personal healing system of im/migrant patients may be plural, and therefore, I end by focusing on the topic of collaborating with professionals in other medical systems for the benefit of the patient. Overall, based on the information from im/migrant patients and their providers about their struggles and the clinical experiences, this chapter contends that care for im/migrants be networked across numerous professions and lay people, depending on the patient's needs and likings.

CHAPTER TWO: BACKGROUND

Historical and Political Economy

Im/migrant is an ambiguous term shaped by social and political forces. Defined by Merriam-Webster as “a person who comes to a country to take up permanent residence,” this definition becomes complicated when considering the differing *local moral economies* the world over that intersect with the lives of im/migrants in their new countries (Willen 2015). Being an im/migrant is more than simply crossing international borders for the purposes of finding a new place to settle. The label relates to the perceptions of the nation an im/migrant enters and why one migrates (Willen 2015). Further, im/migration directly links to inequality, as people move across borders for socioeconomic opportunity, for safety, or any other reason for life improvement (De Genova 2002)..

One problem is that being an *im/migrant* “precludes the possibility of periodic (circular) or permanent return to the country of origin, which is often how *migrants* view their own long-term trajectory” (Castañeda 2010, p. 8). In response, many authors prefer migrant over im/migrant, and one way to emphasize the dynamic between the two terms is to use *im/migrant* and *im/migration* (Castañeda 2010). The point is that many *im/migrants* are actually *migrants* who plan to stay temporarily. Therefore, *im/migrant* is an inclusive term that incorporates the diverse reasons for why and how people move across international borders.

Furthermore, many im/migrants take on an unauthorized status because of U.S. sociopolitical structures that “encourage illegality and deportability, and produce

violence, subjugation, and exploitation” (Castañeda 2010; De Genova and Peutz 2010). U.S. labor interweaves with unofficial im/migration, and U.S. businesses often require unauthorized im/migrants for commercial success and productivity (Holmes 2013). Concurrently, though, immigration policies target im/migrants, creating what Chatterjee (2019) notes as forms of im/migrant labor exploitation. This is the baseline for the obscurity of im/migrant terminology, as the sociopolitical and economic forces at play—both globally and in the U.S.—inform why people im/migrate, how they im/migrate, and how they are treated upon arrival in the U.S. It becomes clear that human im/migration and U.S. policies link with labor markets and socioeconomic systems that thrive on im/migrants while simultaneously imposing virulent, anti-im/migrant policies and rhetoric (Abramitzky and Boustan 2017; Robinson and Santos 2014).

Whether im/migrating temporarily or permanently, fleeing from violence or for economic reasons, all im/migrants deal with disparaging U.S. policies. These policies are designed with im/migrants specifically in mind, but they also influence the greater U.S. social and economic systems—policies that affect all denizens of the United States. To understand why im/migrants and other minority groups suffer from inequities and face barriers to attaining a healthful life, one must delve into the history of the United States—both as a political entity that develops policy and oversees structural systems, and as an entity of cultural “hyperdiversity” (DelVecchio Good, Hannah, and Willen 2011).

Prejudiced Social Structures

The United States prides itself on being a land of opportunity, economic prosperity, and plenty. But even more so, freedom, liberty, and social equality make up

civil discourse—“all men are created equal and endowed with certain unalienable rights” (“The Declaration of Independence”). On the surface, this appears to hold true (Kraus et al. 2019). In theory, any single individual can achieve a safe, secure, and prosperous life for them and their loved ones. A flagrant problem, though, as one digs through the social fabric of the U.S., is that discriminatory structures, both historic and present, have created significant barriers derived from racial beliefs (Kendi 2016). In terms of im/migrants, such fears of The Other— “members of a dominated out-group, whose identity is considered lacking and who may be subject to discrimination by an in-group” (Staszak 2009)—have translated into specific forms of xenophobia that have continually been at odds with conversations about the values and identity of the United States (Noorani 2019). Racial beliefs have not only continually reinforced oppressive social structures and political actions in the United States, but such negative beliefs have historically sparked fears of im/migrants and guided, from both social and policy lenses, which im/migrants are more welcome—deserving—than others (Noorani 2019; Yukich 2013).

Ibram Kendi (2016), in his book, “Stamped from the Beginning: The Definitive History of Racist Ideas in America,” delivers an insightful and well-informed argument for why people of color, and in general people who are *different*, are subject to discrimination, oppression, and marginalization. In brief, Kendi explains that the white supremacy, ingrained in the founding and continuation of the United States, underpins the operation of social and economic systems. This complicitly and implicitly gives favoritism to those of a whiter complexion, and the goal is to protect the discriminatory values at the founding of the United States. In turn, im/migrants have been subjected to

bigotry rooted in such philosophy, and in many ways, much of the distress im/migrants face is because of beliefs originally intended to marginalize based on skin color. The Grassroots Policy Project, an organization focused on combating the social structures that perpetuate injustice, writes,

While the experiences of African Americans and im/migrants have differed significantly, there are a number of parallels in experiences that stem from the racialization of citizenship, im/migrant status, labor, and criminalization. The disparities and exploitative conditions we see today can be traced through these histories of racialization. One clear manifestation is today's criminalization of people of color, both native-born and im/migrant, as well as the criminalization of those who resist oppressive conditions (Hinson et al. 2014, p. 7).

From the Nationality Act of 1790 that limited im/migration to “free white persons” to the Trump administration’s im/migrant separation policy that targets Latinx families at the Mexican border, U.S. im/migration policies directly connect to racist ideals. Indeed, Sundstrom and Kim (2014) explain how histories of xenophobia have historically hinged on race and often inform nativist discourse and language surrounding im/migrants.

Im/migration Policy

While always present in some form throughout U.S. history, we can trace a large part of the recent xenophobic wave that has come across the United States to the 1965 Immigration and Nationality Act, also known as the Hart-Celler Act. Prior to its passing, the U.S. based its im/migration system on a national origins quota that limited im/migration to three percent of the nationality resident population—the number of people from a certain country of origin—already in the U.S. (Douglas 2008). For example, if 1,000 people from Cambodia already im/migrated and lived in the U.S., the

im/migration system would permit three percent of this number of Cambodian citizens (30) to im/migrate. In contrast, if 100,000 people from France already lived in the U.S., three percent of this number of French citizens (3,000) could im/migrate. Resultantly, the act gave preference to those of Western European origin by differentiating relative to perceived ability to assimilate Americanness. “The goal of the National Origins Act was to control both the quantity and quality of U.S. im/migrants in an effort to prevent further erosion of the ethnic composition of U.S. society” (Douglas 2008, p. 938). With good reason, Hart-Celler changed this system, replacing the three percent nationality quotas with visa categories and new im/migration paths through family reunification. The outcome is the multicultural U.S. we see today. “Hart-Celler signaled an end to Europe’s dominance as a sending region, and opened the doors to renewed large-scale immigration” (Wolgin 2013, p. 61).

Im/migrants from all over the world flocked to the United States, bringing in new populations from East Asia, Latin America, and Africa. “The share of the U.S. population born outside the country tripled and became far more diverse. Seven out of every eight im/migrants in 1960 were from Europe; by 2010, nine out of ten were coming from other parts of the world” (Gjelten 2015). This 1965 legislative policy is the beginning of the im/migration debate we see today, and while not a xenophobic act of policy itself, it is at the core of the discriminatory, conservative, and nativist rhetoric that attacks im/migrants as destroying American values (Quinonez 2018).

The fear and anxiety coursing through our nation are a function of cultural change brought on by rapidly shifting demographics [...] Instead of doing to others what we would have done to us, we separate im/migrant families at the border, treat

asylum seekers as criminals, and claim that our nation is being invaded (Noorani 2019, p. 6 & 124).

As more im/migrants have entered the United States, subsets of native-born Americans have become scared—there is an expressive fear of change in the American sociocultural landscape because of The Other.

Neoliberal Citizenship

To see the larger picture, however, considering the economic dynamics that structure social gradients—“the phenomenon whereby people who are less advantaged in terms of socioeconomic position have worse health (and shorter lives) than those who are more advantaged” (Donkin 2014)—may prove helpful. A hallmark of the United States is capitalism. It has seeped into the foundation of American ideals and is the overarching characteristic of the U.S. economic system. In a 2018 special issue by the Journal for Cultural Research, authors Cole and Farrarese (2018, p. 108) frame capitalism as a “form of life.”

By redefining capitalism as a form of life, it can be analyzed as a social practice, rather than as a system radically distinct from the cultural, social, political or even biological. When economics is conceived as a discrete activity or sphere, the reciprocal impact of the economy on our lives and our lives on the economy recedes to the background: it appears as isolated and autonomous, a function of instrumental rationality or the market (Cole and Ferrarese 2018).

Put another way, we should not consider capitalism in isolation nor as simply an economic system; capitalism is an all-encompassing phenomenon that takes center stage in U.S. life. In many ways, capitalism becomes second nature, yet we experience its intersection into our lived reality relative to social stratification. Nothing and no one can escape capitalism in America, and many individuals suffer unduly in the face of

unchecked free market principles (Mavelli 2018). With this in mind, American capitalism is incredibly “disorganized” (Offe 1985) and im/migrants suffer this wrath of socioeconomic inequality perhaps more than any other population. For example, in terms of unauthorized im/migrant labor, as Seth Holmes (2013) explains in his book *Fresh Fruit, Broken Bodies* and Sarah Horton (2016) in her book *They Leave Their Kidneys in the Fields*, market forces demand production without high labor costs and regulatory oversight, which leads to the commodification and exploitation of im/migrant workers’ bodies without adequate provision of safe working conditions or access to healthcare services.

Moreover, the U.S. centers its immigration policy on “deservingness,” which refers to an im/migrant’s ability to assimilate aspects of Americanness—to thrive in the American capitalist order (Abramitzky and Boustan 2017; Mavelli 2018; Yukich 2013). Kibria and colleagues (2018) note that *deserving* vs. *undeserving* themes are “central in contemporary politics of immigration control” (Kibria, O’Leary, and Bowman 2018; Kibria and Becerra 2020). The U.S. welcomes im/migrants that seamlessly interweave into the neoliberal way of life, while simultaneously vilifying im/migrants considered a *public charge* (Kibria, O’Leary, and Bowman 2018). Mavelli (2018, p. 482) calls this the “neoliberal rationality of government that is rewriting the meaning of belonging.”

Just as Cole and Ferrarese (2018) frame capitalism as a “form of life,” Mavelli (2018) conceptualizes neoliberalism—the “emphasis on markets, minimal states, and individual choice as a means of ensuring economic and social well-being” (Larner 2009)—as a phenomenon that exists in “all spheres of human activity,” valorizing

entrepreneurial spirit across all residents, im/migrant or not.

In the neoliberal political economy of belonging, inclusion and exclusion are increasingly becoming a function of an individual's, or a group's, capacity to contribute to the country's financial viability, economic competitiveness, international reputation, moral standing and self-understanding, and emotional well-being" (Mavelli 2018, p. 482-483).

Crucial to Mavelli's argument is that the state propagates neoliberal ideals and policies, contradicting the esteem of Adam Smith's free market society. In terms of Foucault, this is an *economization* of the state—governmental construction of a nation that adheres to neoliberalism and the exclusion of those who do not follow this "regime of life" (Foucault 2010; Stevenson 2014).

Subsequently, citizenship, while a result of geographic position at birth and/or governmental processes of surveillance, documentation, and regulation (obtaining citizenship through USCIS), also ties to a person's relative market value—the economic benefits one brings to the United States, and more so, the likelihood of whether one will be an economic burden (Somers 2008). This "market fundamentalism"—the neoliberal emphasis of laissez-faire economics—as Somers (2008) terms it,

weakens civil society by undermining reciprocities and solidarities, contractualizing human relations and making social inclusion dependent upon successful participation in market transactions. The result is a transformation of citizenship itself, from an unconditional status of membership to a contingent accomplishment. Increasingly, a significant proportion of people who are formal citizens in the United States become effectively stateless persons (Olin Wright 2011, p. 8).

This is roughly equivalent to saying that when the state withdraws from the responsibilities of providing public benefits for those in need, one must have money or the skills to make money in order to meaningfully participate in U.S. society.

In response, there has been a historical *hardening* of borders for refugees and asylees, and for that matter any im/migrant who may seemingly burden the system as related to the country's economic goals (Becker and Coyle 2011). The Trump administration had only exacerbated these efforts in recent years. For many im/migrants, there is a newly strengthened *violence of uncertainty*—"policies of uncertainty intended to create systematic insecurity by constantly changing the terms of daily life and targeting what matters most to [im/migrant] people—by separating im/migrant children from their parents or ending reunification of refugee families" (Grace, Bais, and Roth 2018, p. 904).

In terms of im/migrant deservingness within this neoliberal framework of citizenship, Chatterjee (2019) notes the "contemporary settler-colonial" Western countries implicitly enforce. Chatterjee elaborates the settler-colonial as the preferred, unwritten qualities im/migrants need to abide by relative to the historically White colonial, neoliberal state; "a tightly wrought grid of historic and ongoing capitalist colonial exploitation of land and labor, racialized precarity, and psychic and socio-legal legitimization of White European settlement" (Chatterjee 2019, p. 646). Moreover, the settler-colonial is a social process and structure that relates to political ideals of settler nationalism, or how im/migrants 'ought to be' in the U.S. political economy (Wolfe 2013). But it is also a component of a much larger system of violence that affects im/migrant health.

Structural Violence

In his highly cited article "Violence, Peace, and Peace Research," Johan Galtung (1969) introduced the theoretical concept of structural violence. He argued structural

violence exists as violence that does not have an evidently discernable actor, arguing that such results from unequal distributions of power and life chances (ibid. 1969). Galtung conceptualizes these forms of violence as rooted in the social structures and laws that encompass everyday life. Certain peoples are discriminatorily targeted to suffer through grand schemes of social arrangement that operationalize inequality. Anthropologist Paul Farmer, another prominent structural violence scholar, writes that the “arrangements are *structural* because they are embedded in the political and economic organization of our social world” (Farmer et al. 2006, p. 1686). “They are violent because they result in avoidable deaths, illness, and injury; and they reproduce violence by marginalizing people and communities, constraining their capabilities and agency, assaulting their dignity, and sustaining inequalities” (Rylko-Bauer and Farmer 2016, p. 47). Redlining, poor access to healthy foods, limited school supplies in low-income areas, clogged court systems, inability to receive documents in languages of choice, stringent immigration and deportation policies, or anything else that unduly makes life harder for any single individual or group are examples of structural violence.

At its roots, then, structural violence is about constraints to personal agency and limiting opportunities The Other has for success. Because of barriers that perpetuate poverty, social exclusion, and disempowerment, the people that live on the margins of society face immense uphill battles to climb socioeconomic and sociocultural ladders. Structural violence, to a point, limits decision-making in the actual world, adding depth to why certain populations are pushed to the bottom of social gradients. The fact of the matter is that the U.S.’ socioeconomic and political structures and systems are

inequitable, and because of that, marginalized populations such as im/migrants face structural vulnerabilities to their health (Bourgois et al. 2017; Quesada, Hart, and Bourgois 2011). Significantly, recent actions of the state have greatly intensified im/migrant vulnerability, as the Trump administration criminalized and devalued im/migrant identity and social worth more than ever (Abrego et al. 2017; Saleem et al. 2016). This, in turn, has shed renewed light on immigration as a structural determinant of health.

Im/migrant Identity as a Social Determinant of Health

Taking a socioecological lens to examining im/migrant health, Castañeda and colleagues (2015) describe how simply being an im/migrant in the U.S. is a social determinant of health (SDH). One of the foremost contributions of public health scholarship, SDHs are about “appreciating the role of social factors in health” (Braveman, Egerter, and Williams 2011). Aspects of an individual’s environment—socioecological world—affect individual and communal health. Location, education, income, safe and secure housing, food access, and adverse childhood experiences (ACEs) are just a few of what we could consider SDHs. In sum, they concern how “the conditions in which people are born, grow, live, work and age shape health” (Artiga and Hinton 2018). However, SDHs also go beyond the tangible and consider all parts of *the social* (Swedberg 2014) in relation to health. It is not just the directly discernable environmental factors that reduce health, it is also those that are sociopolitically constructed and symbolically ingrained—particularly in relation to identity.

Theorists of intersectionality posit “that multiple social categories (e.g., race,

ethnicity, gender, sexual orientation, socioeconomic status) intersect at the micro level of individual experience to reflect multiple interlocking systems of privilege and oppression at the macro, social-structural level (e.g., racism, sexism, heterosexism)” (Bowleg 2012, p. 1267; Crenshaw 1991). Identities exist on a continuum of favorable vs unfavorable relative to larger U.S. sociocultural preferences, resulting in privilege. Dominant identities receive social benefits at the expense of less-dominant, or targeted, identities. Simply identifying as LGBTQ+, disabled, Muslim, Jewish, low-income, an im/migrant, or any other targeted identity, may bring harm to well-being (Gadsden 2016).

For im/migrants in the current U.S. political climate, the identity of im/migrant is steadily attacked. As I previously noted, the political rhetoric around im/migrants is increasingly being associated with invasion, and the overarching tone is that im/migrants do not belong and are a threat to American values. Braveman and colleagues (2011) note that SDHs require an upstream approach that combats the greater macro level *why* of an SDH—in this case, why im/migration determines health. Sure, perhaps the “complete realignment of daily life” (Castañeda et al. 2015) and the experiences of trauma some im/migrants experience informs health. In part, they do. But, more often than not, the other challenges im/migrants face such as poverty, under and unemployment, insecure housing, and political persecution that affect health are structurally rooted. At the core of the problems im/migrants deal with is being an im/migrant, and the problems with being an im/migrant in America come from the state. This makes im/migration in and of itself a determinant of health.

Conclusion: The Lifeworld

My goal is to argue for a provider embodiment that understands the structural influences on the im/migrant patient's construction of their *lifeworld* (Epstein and Street 2011; Harrington 2006). First developed by Edmund Husserl and Alfred Schutz, lifeworld is a phenomenological concept which accounts for the "common-sense reality" of the social world one lives (Harrington 2006). Relative to one's experiences, upbringing, cultural background, ethnicity, religion, age, job, or otherwise, one holds memories, beliefs, and values that are wholly unique. However, paramount to the theory of the individual's subjective lifeworld is the shared intersubjective world.

Schutz (1945) emphasized the theoretical concept of intersubjectivity as a means by which bodies organizationally interact and communicate. Throughout human history, forms of human interaction have built and changed societies, informing ways of being. Indeed, Schutz agreed with philosopher Max Scheler's position that "the 'We' is given prior to the 'I'" (Barber 2018). We are born into informed worlds with established customs and manners of living. Of course, there are many nuanced ways individuals and groups go about living life. However, in any given populated area (e.g. The United States) there are overarching, pervasive values and tenets — "worlds of daily life". This is what Schutz means by an intersubjective world. "The intersubjective world which existed long before our birth, [is] experienced and interpreted by others, our predecessors, as an organized world" (Schutz 1945, p. 533).

Pierre Bourdieu called this the existence of *habitus*, or how social and/or community organization informs individual physical embodiment and behaviors

(Crossley 2001). For im/migrants to the U.S., their lifeworlds may be highly dynamic due to movements across borders into new countries—social worlds—with different intersubjective histories and *habitus* than accustomed.

Furthermore, the social world of the U.S. during the Trump presidential administration was callous and cruel towards im/migrants. Perceptions of im/migrants deteriorated, and sociopolitical forces sought to cause them harm—the state’s targeted effort of *othering* im/migrant people. Stress rooted in politically influenced forms of violence intersect the lifeworlds of im/migrants, and in response, cause suffering. (Grace, Bais, and Roth 2018; Derose, Escarce, and Lurie 2007; Kleinman 1997).

Migration Phases and Im/migrant Health

I began my background section by stating the ambiguity of the term im/migrant. This ambiguous nature partly stems from the multiplicity of im/migrant experiences that construct different im/migrant typologies (e.g. refugee, asylee, unauthorized, etc.). Depending on the general mode of and reason for im/migrating, the state puts im/migrants into labeled categories reflective of law and colloquial language. These labels, however, by no means reflect the overarching experiences of the individuals under them. “We must be careful not to cluster migrants and their associated lived experiences to simple, reductionist categories” (Wickramage et al. 2018, p. 4). That said, these labels are helpful for research purposes and for discerning the needs of certain im/migrants relative to migratory experiences. Every im/migrant has their own im/migration journey, but there are patterns in im/migrant typologies that direct research inquiry and clinical practice.

Wickramage and colleagues (2018) determined four chronological stages that im/migrants move through. These are the *pre-migration* phase, the *movement* phase, the *arrival and integration* phase, and the *return* phase. Again, every im/migrant experiences these phases differently, but there are larger patterns that indicate clinical and social needs across im/migrant types. For example, every im/migrant has an arrival and integration phase, but a refugee and someone on a H-1B visa (specialty occupation) will have different im/migration experiences. However, relative to aspects of xenophobia and nativism, there may also be similar experiences after arrival. Im/migrants are one population, but they are also many. The goal, as I provide background on the health of im/migrants, is to outline the general health and health needs of im/migrants relative to these four phases of migration, but I will also present research findings relevant to specific im/migrant typologies.

To provide additional context, I have also incorporated another lens for examining health during and after migration. Silove (2013) developed a means of examining stress at different migratory stages and how interactions with state and civilian actors affect health. While originally developed as a means to explore migratory stress among refugees, I expand this approach to include any im/migrant. Silove's model considers five pillars: *personal safety*, *attachment and bond maintenance*, *identity and role-functioning*, *justice*, and *existential meaning*. As Warfa et al. (2012, p. 2) who have also used this framework recognize, "The model provides a useful heuristic for understanding the development of illness at the different stages of migration and the way in which interactions between different mechanisms may aid or hamper health." Relative to the

experiences of a specific migratory journey, inclusive of all phases, these pillars are either helped or harmed in terms of individual and familial wellbeing. Silove terms his model the ADAPT model, and while the theoretical concept of *im/migrant adaptation* has its faults (Skerry 2000), I think this is specifically why he chose the name.

The pillars Silove identifies connect with systems of adaptation that cause stress and illness across the im/migration journey. This becomes helpful when considering the different im/migrant typologies and how they experience im/migration to a new country. *Why do certain im/migrants experience more stress to the five pillars than others during the phases of im/migration?* The differential conditions of and for movement across international borders, in combination with patterns of adaptation to the U.S. upon settlement (e.g. deservingness, job-skills, education level, ability to speak English, established social connections, etc.), influence im/migrant health outcomes.

“A core postulate of the ADAPT model is that the psychosocial pillars overlap and interact [...] the greater the undermining of several pillars, the more likely that foreground experiences (cumulative trauma and stress) will lead to adverse health outcomes” (Tay and Silove 2016). The pillars are not mutually exclusive, and their destruction can occur in tandem at the social and individual levels across the im/migration journey. If the pillar of *personal safety* is wrecked, so too may the pillars of *attachment and bond maintenance, identity and role-functioning, etc.*

Im/migrants, as they experience relocation—the migration phases and stress to the pillars of adaptation—due to means beyond their individual control, impute personal meaning to their experiences of violence. “The [ADAPT] framework reinstates the notion

that humans attempt to ascribe meaning to events and the contexts in which they occur, in doing so linking past experiences [memories] with present conditions and future eventualities” (Tay and Silove 2016, p. 143).

Refugees spend years in crowded and unsanitary humanitarian camps awaiting receipt of entry to a resettlement country (Devictor 2019). Asylum seekers walk hundreds of miles to U.S. borders only for immigration personnel to treat them inhumanely—sterilized, put in cages, and separated from family (Chapkis 2003; Davis and Shear 2018; Jackson 2020). Unauthorized agricultural workers face a perilous journey across militarized U.S. borders only to gain seasonal employment in poor working conditions for less than minimum wage (Lopez 2007). A K-3 visa recipient (spouse of a U.S. Citizen awaiting approval of an I-130 im/migrant petition) may spend years separated from loved ones, but can hop on a plane directly to the U.S. once USCIS permits their entry. Why im/migrants experience stressors, where they occur, by whom they occur, and when, as connected to im/migrant typology and migratory journey, tell a story of illness, and subsequently, the delivery of care.

Pre-Migration Phase

The pre-migration phase consists of the events and reasons for im/migrating. This is often the most critical step in the im/migration process, as the life of the im/migrant in their country of origin is at the foundation for moving to a new land. Refugees, asylees, and unauthorized im/migrants experience conflict, persecution, and violence as their reason for im/migrating (Perreira and Ornelas 2013; Steel et al. 2009), otherwise called *forced migration*. In comparison, an H-1B (specialty occupation) or student visa recipient

may not have these same stressful and traumatic experiences. Therefore, the *why* of im/migration connects with an im/migrant's health status and needs upon settlement.

Davin (1999) states that people im/migrate “so they can improve their own lives or those of their families by doing so”—life is not going well and better opportunity, safety, and quality of life lies elsewhere. This itself is meaningful, but the context of what an im/migrant is improving upon is somewhat more important. The factors connected to the im/migrant's originally reduced quality of life, such as poverty, land shortage, draught, torture and persecution, natural disaster, war, etc. affect their pre and post-im/migration lives and health. The specifics matter, as the foundational reasons for transnational movement, and the connected experiences thereof, correlates with illness development.

Movement Phase

Im/migration inherently involves movement—it means to settle someplace else. However, what occurs during such movement and how this relocation occurs affects health. Wickramage and colleagues (2018) note four primary domains relative to health during the movement phase of migration: the duration of the journey, the mode and conditions of travel, whether it is a single or mass movement, and experiences of violence and abuse. Refugees, asylees, and unauthorized im/migrants often walk a portion, if not all, of their migration trek (de Córdoba and Montes 2018). Or, they may cross large bodies of water, such as the case with forced migrants from North Africa and the Middle East traversing the Mediterranean Sea to reach Europe (Kassar and Dourgnon 2014). These “desperate journeys,” as the UNHCR (2018) terms them, are often rife will

occurrences of sexual and physical violence, limited access to food and water, thievery, strenuous travel conditions, and death (Arsenijević et al. 2017; Servan-Mori et al. 2014; United Nations High Commissioner for Refugees 2018, 2020a). Such experiences gravely challenge all five of Silove’s pillars, however, none more so than personal safety.

The danger forced migration poses to the body and mind is tremendous, and the repercussions could last a lifetime. It is a serious journey; one im/migrants do not consider lightly. This is why Silove (2013) distinguishes traveling in groups—*migrant caravans*—versus alone or in smaller company. There is safety in numbers, and im/migrants realize that the journey is safest when the masses move together (Jacobsen 2018). This brings up a point that im/migrant typologies overlap. Refugees and asylum seekers move across international borders for very similar reasons and under equally brutal conditions. Legal categorizations, however, create different entry experiences, and resultantly, possibilities of citizenship and social belonging.

Arrival and Integration Phase

Peña-Sullivan (2019) calls attention to the idea of “the wrong kind of im/migrant.” The U.S. considers some im/migrants as preferred—more deserving—than others. This deservingness, as I noted in earlier background information, relates to racism, xenophobia, and an im/migrant’s potential “market value” in the U.S. economy (Mavelli 2018; Ong 2006; Somers 2008). But this deservingness also relates to how an im/migrant enters the U.S. and why im/migration occurred to begin with. Such categorization of im/migrants sets diverse stages for integration, citizenship, and health (Willen 2012).

USCIS rigorously vets refugees prior to being considered for resettlement in the U.S. and eventually being granted visas. Their histories, their bodies, and their lifeworlds are examined for any reason not to be allowed into U.S. borders. A point of significance is that the refugee determination process occurs across borders, so refugees are already on a path to citizenship upon arrival. They live in the U.S. legally, can apply for a green card after one year, and can apply for citizenship after five years. In addition, the refugee label comes with the advantages of an official status that provides certain government benefits and privileges compared to other im/migrants (Ludwig 2016). However, the term refugee also connotes powerless victims of trauma in need of protection and support, as well as state surveillance (Kalhan 2014). Legal refugee status and the informal refugee label are not the same thing. Part of the issue at hand is that refugees, as well as any im/migrant applying for asylum, needs to validate a traumatizing, victimizing past to enter the U.S. and receive benefits, services, and the opportunity for future citizenship (Besteman 2016). The refugee label is only advantageous when it comes with material benefits and entry to the United States; otherwise, the label is just a reminder of forced migration and a reinforcement of localized stereotypes about refugees (Ludwig 2016).

I also think it is worth noting that refugees do not apply for refugee status themselves. They flee their home country and become a refugee once crossing an international border. At this juncture, the United Nations High Commissioner for Refugees (UNHCR) identifies only the most vulnerable cases for resettlement according to four categories of vulnerability: medical needs, women and girls at risk, children at risk, and survivors of violence/torture (UNHCR 2020b). It could be argued that all

refugees meet such criteria, but the U.S. government screens one's provenance. They employ in-person interviews, background checks, and medical tests as the deciding factors, and from the outset, the U.S. treats refugees as a threat which requires examination and control—The Other.

The arrival procedure for asylum seekers starts within the confines of U.S. borders, beginning with the affirmative asylum process or the “arriving” asylum seeker process. Here, an affirmative asylum seeker applies for asylum with USCIS at a port of entry and waits for an approval or rejection of their application. “Arriving” asylum seekers go through these same steps, but they first arrived in the U.S. with a separate visa. In either case, if USCIS accepts their application, they are given formal asylum status. However, if USCIS denies their application, defensive asylum proceedings commence. At this juncture, the asylum seeker defends their case in immigration court, and the result is either the judge reversing the initial rejection of the asylum application or deportation.

To be eligible for asylum, an im/migrant must submit an I-589 form with USCIS (Application for Asylum and for Withholding of Removal) within one year of arrival. Asylum seekers must meet the criteria for refugee status in order to be granted asylum, “a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group, who has been forced to flee his or her country because of persecution, war or violence” (United Nations High Commissioner for Refugees 1951). No matter if an asylum seeker enters the U.S. unauthorized, the only difference between refugee status is that *asylum* is sought within or at U.S. borders (United States Citizenship and Immigration Services 2020).

Regarding the benefits of the refugee label compared to that of asylees, there is a disparity of deservingness. This is not to deny the struggles refugees face prior to and during resettlement in the U.S., but the comparative benefits each of these im/migrant typologies receives does not correlate with commonality between reasons for and experiences of im/migration. Asylum seekers, as they await the determination of their case, receive no federal benefits, are not eligible for work (for the first 150 days), and they cannot rent housing; they are barred from accessing the resources and benefits that many others in U.S. society enjoy unless USCIS or a federal judge approves their application. Like an electrical current, this visa insecurity conducts anxiety, fear, and uncertainty throughout the life, body, and mind of the asylum seeker (Newnham et al. 2019).

Despite the difference between vetting and asylum determination within or beyond U.S. borders for refugees and asylum seekers, both processes demand a retelling of the im/migratory journey—proof that one’s past is perilous enough. Refugees undergo these proceedings through in-person interviews *overseas*. Asylum seekers endure this in U.S. immigration court. Regardless, there is an implicit need to remember, and within the context of neoliberalism and the desire for im/migrants to integrate Americanness, I argue that memories of home and migration become an entangled mess that im/migrants both need to remember and neglect. Pre and post migration memories, both joys and horrors, are put at odds with the American dominion’s desire for im/migrants to forget the homeland and integrate the preferred “settler-colonial”. Asylum seekers and refugees

must exhibit a past—a memory—worthy enough of gaining entry, but also display a willingness to forget enough aspects of the past to assimilate into an American future.

An im/migrant “has” memories of the homeland, or saved visuals of a land and time evocative of longing, but also wrought with dread. The U.S. version of successful integration propounds that such memories and attachments to home and life be slashed—violence in and of itself—to protect American society. Both an im/migrant and the U.S. government, therefore, understand the presence and significance of foreign memories. They derive relations of difference. For the im/migrant, it is to remember where they come from and grow from what they have experienced. For the United States hegemony, it is to protect where im/migrants are coming to and safeguard what U.S. society has grown. They only differ in how they perceive memories—whether a source of guard or a source of threat (Besteman 2016).

Unauthorized im/migrants, in contrast, do not retell their story to governmental actors for entry into the United States. They cross into and live within U.S. borders illicitly, resettling away from the gaze of the state. For fear of deportation and that their history does not warrant asylum status, they do not apply for asylum with USCIS. Their lives depend on inconspicuousness. Further, such fears of deportation because of unauthorized status push people away from government associated services, such as healthcare (Duncan and Horton 2020; Grace, Bais, and Roth 2018).

Such fear is not just associated with deportation, however. Refugees and approved asylum seekers who have yet to attain citizenship avoid government assistance to avoid becoming a “public charge.” The public charge rule, which has been an enforced policy

since 1999, “governs how the use of public benefits may affect individuals’ ability to enter the U.S. or adjust to legal permanent resident (LPR) status (i.e., obtain a “green card”)” (The Henry J. Kaiser Family Foundation 2019). The Trump administration, however, broadened the policy to include histories of receiving health, nutrition, and housing aid from public programs. While the Department of Justice withdrew these additions to public charge in December 2020 (American Immigration Lawyers Association 2021), such policies, again, support the notion that subsets of the U.S. population want im/migrants who have readily discernible economic value. The im/migrants who do not are shunned away from seeking asylum, and instead, they cross the border unauthorized and face the hardships of life in the shadows.

All this said, legally im/migrating to the U.S. outside of refugee or asylum status is highly difficult. It is an intricate process with established criteria that, if one does not meet, makes legal im/migration to the U.S. with a path to citizenship impossible. Family reunification (a keystone of the Hart-Cellar Act) and skilled employment are the predominate means of legal immigration to the U.S. (i.e. people who already have socioeconomic supports and/or the occupational skills for self-sufficiency). If one does not meet these conditions, legal im/migration is unfeasible.

Return Phase

As I noted from Castañeda (2010), many im/migrants do not plan to stay permanently. There is a desire to one-day return, or simply visit, the homeland. Dependent on im/migrant typology and the means of entry, however, this may be impossible. Refugees and asylees, because of the nature of their reasons for im/migrating

to the U.S. (legitimate fear for life), may not return home without forfeiting their status. The act of leaving international borders puts one's legal status and the path to citizenship at risk. However, once gaining U.S. citizenship and procuring a passport, one may internationally travel as U.S. law permits. Unauthorized im/migrants, however, due to the hostile and dangerous conditions of unlawful border crossings, usually do not dare return home unless originally planned, they do not plan on returning back to the U.S., circumstances warrant, or they have received a visa or citizenship. The risk is often too great (De Leon 2015; Gálvez 2011).

An aspect of great importance, though, is that kinship relationships and connections to home persist no matter the length or type of im/migration (Andrikopoulos and Duyvendak 2020). One has to leave a world and their people behind, and often, as Wickramage et al. (2018) note, im/migrants also change with their shifted surroundings. Our social worlds are hardly stagnant, and for that matter, neither are societies at large. Social landscapes change over time, by the people and of the people, both home and abroad; people both change and cause societal change. Therefore, when im/migrants leave, the worlds and people they know alter as time goes on—and they too change as they live in new lands (Richerson and Boyd 2008). Im/migrant kinship networks, in response, seek to combat these forces, persisting familial connections across thousands of miles.

Galvez (2011), in her book *Patient Citizens, Immigrant Mothers*, tells the story of a young, unauthorized im/migrant Mexican mother suffering from morning sickness, and then after giving birth, postpartum depression. Back home, her mother would have made

special teas and soups, in addition to running a unique herbal steam bath. The woman's husband, recognizing what his wife required, contacted his mother-in-law and learned how to make the concoctions and bath. He took upon roles traditionally held by women—the caring of the mother and infant—because of migratory needs. Distance forced him, the woman, and the mother-in-law to adapt and find ways to protect and exercise their cultural practices from Mexico.

Such an example exemplifies the return phase—developing a life in the U.S. in tandem with the homeland. *Return* is not just a movement back home across borders, it is about *proculturating* a life in the U.S. that is inclusive of home (Lado Gamsakhurdia 2019). Using the metaphor of “fusion-cocktails,” Lado Gamsakhurdia (2019) argues that im/migrants can adapt a culture that fuses their old and new ways of sociocultural being. When people im/migrate, they do not have to acculturate or enculturate. Rather, they can *proculturate* novel forms of being that coalesce the past and present. It is a middle ground that conceptualizes im/migrants as able to stay connected with the cultures of their homeland and those of their current surrounding without establishing that any one way of life is lost or imposed upon, or that any single culture is better than another. The term gives room for people to create new blends of being that are cultures of their own, adhering to the deeply rooted and the freshly rooted, and the people near or across borders that make it so.

Proculturation results in the creation of fusions of new meanings, which are dialectical synthesis of priorly unfamiliar and familiar, foreign and heritage ideas and leads to the meaningful transformation of the self [...] those created new meanings are shared with environment and create catalytic conditions for its further reconstruction [...] Proculturation is dialogical in its essence.

Proculturation is encouraged by the urge for self-presentation (Lado Gamsakhurdia 2019, p. 173).

Im/migrants actively and passively build new, hybrid ways of life, being, and self that accommodate both the current world around them and the old world they left behind.

Constraints and Barriers

At the core of im/migration as a social determinant of health are the socioeconomic factors that cause im/migrants stress. The notion of ‘making ends meet’ is an oft concern among im/migrants, and they regularly work low-paying service or manufacturing jobs (Derose, Escarce, and Lurie 2007). These financial insecurities and constraints to agency translate into toxic stress, resulting in health problems (Ayón 2018).

However, this stress becomes complicated when considering pre and post im/migration factors. Refugees and asylees, who are forced out of their countries of origin for reasons of safety, are unprepared for the challenges of moving to a new country (Castañeda et al. 2015). Further, such populations of im/migrants, due to the conditions of their home countries, often experience traumatic events. These trauma histories, in combination with the stress of settling in new countries, results in health problems frequently in the form of mental unwellness (Kirmayer et al. 2011; Steel et al. 2009). These factors are exacerbated when considering the violent rhetoric and policy actions targeted at im/migrants during the Trump administration (Bustamante et al. 2018). Authors in im/migrant studies have termed this manifestation as *acculturative stress*—stress at odds with proculturation.

“Acculturative stress consists of psychological and social stress experienced due to an incongruence of beliefs, values, and other cultural norms between a person’s

country of origin and country of reception” (Da Silva et al. 2017; S. J. Schwartz et al. 2010). When im/migrants move to the United States, no matter how much is gained, much is also lost. With this loss comes unfamiliarity and strife as one finds themselves in a society that is difficult to navigate with limited resources for assistance. All social functions change, and the ways of life and being that im/migrants know are put at odds with that of new lands and peoples. The uneasiness that comes with this stress—this loss—puts the health of im/migrants at risk. This risk is worsened when considering the stress U.S. social structures puts on im/migrants. In many ways, the U.S. is a danger to im/migrant health (Gálvez 2011).

Language

One of the most significant health related barriers for im/migrants is language (Morris et al. 2009; Gilmer 2018). Language barriers have the broadest influence on im/migrant access and reception of health care, having been found to affect scheduling appointments, getting to the clinic, giving a medical history, communicating with providers, picking-up prescriptions, giving informed consent, and much more (Morris et al., 2009). Further, language barriers also impact healthcare providers’ ability to treat im/migrants and form effective therapeutic relationships, or a “therapeutic alliance” (Miller et al. 2005). Language barriers can affect clinical assessment of risk factors and analysis of symptoms, which can lead to inaccurate diagnoses (Meuter et al. 2015). Moreover, providers need to employ effective communication to acquire accurate medical and family histories, as well as ensure LEP (limited English proficient)

im/migrant patients understand them and the treatment plans put forth (Coren, Filipetto, and Weiss 2009).

Indeed, numerous providers and patients I spoke with mentioned the significance of linguistic interpretation, and during my observations of resident precepting at Boston Medical Center, the application of interpretation was always a matter of consideration—there is no denying that it is a necessary component of im/migrant care and clinical competence for healthcare providers (Basu, Costa, and Jain 2017). However, because of this necessity, my discussions in this thesis do not discuss the presence or use of interpreters. Rather, I take a subliminal position that providers use linguistic services when patients require. I do not mention interpretation, but presume it is there. My point of departure is not to limit the significance of linguistic interpretation, but to shed light on other areas of communicative importance for im/migrant patients.

Such aspects I assume include speaking slowly in short, concise sentences, using first-person language that addresses the patient directly, using a consistent in-person interpreter (if able), acknowledging the difference between professional and ad hoc interpreters, and recognizing the presence of a therapeutic triad (patient, provider, and interpreter) (Juckett and Unger 2014; Resera, Tribe, and Lane 2015). Furthermore, such an understanding of language differences also entails the navigational barriers LEP causes im/migrant patients. Every patient I interviewed mentioned language as a barrier outside of the medical encounter. Scheduling appointments or referrals, getting to the clinic, navigating the hospital, picking up prescriptions, reading food labels, and more have affected their health outcomes and abilities to access and receive quality care. To

add, patients also noted how LEP has social implications that negatively affect employment, education, class standing, and a sense of American belonging. In agreement, literature confirms these statements about the overarching significance between LEP and low socioeconomic status (Olsen 2000; Sentell and Braun 2012; Shields and Wheatley Price 2001). To put it simply, in the U.S., regardless of im/migrant status, not knowing English is a social determinant of health.

These factors regarding communication through interpreters, as well as the effect of LEP on the clinical encounter and social positioning of im/migrants, again, are underlying assumptions of practice I make throughout my thesis. Without the clinical use of interpretation services or provider knowledge of how LEP pertains to social stress, my arguments are moot. If an im/migrant patient does not speak English, the provider must have the capability to use interpreter services and recognize how LEP may affect their patient's social life, needs, and care experiences.

Coverage

An additional and politically contested healthcare barrier for im/migrants is healthcare coverage. Focusing on Massachusetts in particular, Joseph (2018) describes how state coverage for im/migrants is intentionally stratified relative to im/migration status. Her argument ties into the theoretical concept of “bureaucratic disentanglement” as Danz (2000) and Marrow (2012) discuss. The term refers to legal inclusion, but “informal exclusion.” There are coverage options available to both authorized and unauthorized im/migrants, such as MassHealth, MassHealth Limited, and Health-Safety-Net. But to apply for and receive such benefits, barriers exist. “Documentation status, difficulty

producing eligibility information for coverage (re)enrollment, LEP, and immigration enforcement negatively affect im/migrants' ability to sign up for and obtain health coverage" (Joseph 2018, p. 85). Despite the *ability* to enroll in state sponsored coverage, the steps to doing so prevent im/migrant participation. An im/migrant may not be able to collect a paystub because they work under the table, or an im/migrant may not be able to provide proof of residence because their name is not on a deed or lease. Or, they may not hold a credit rating because they do not have a bank account or social security number. Regardless of eligibility, im/migrants sometimes cannot produce the required documents or do not have the necessary resources.

This decision not to enroll, however, is also related to additional policy efforts that influence im/migrants in particular. The public charge rule, even with the Department of Justice's recent withdrawal of the recent policy changes, prevents application. Further, bureaucratic disentanglement also concerns a lack of information about policy. Joseph (2018) adds that many of the participants in her study were unaware of the coverage options offered by Massachusetts, and for those that were enrolled, they did not know they had to reapply every year. In addition, these enrollees also faced difficulties figuring out where their coverage is accepted and paying the deductibles and copayments in their plan.

In sum, Joseph (2018) describes a system which, on the surface, im/migrants have the coverage options they need to access healthcare. Options and eligibility may differ across states, but central to Joseph's argument is that efforts to stratify im/migrant coverage exist in all state policies across the country. Im/migrants have to provide certain

documents, understand how to enroll, and have the financial capabilities to pay accompanied costs. As Marrow, Joseph, and Danz posit, the bureaucracy disentitles im/migrants from the coverage options afforded them.

Transportation

A significant, but frequently overlooked barrier to care is transportation (Syed, Gerber, and Sharp 2013). For im/migrants, this is an intensified concern. First, navigating cities and public transportation systems is a troublesome ordeal for im/migrants who may be unfamiliar with the layout of the city or how the transportation systems in their area work (Bailey et al. 2019). Moreover, these issues become compounded if one does not speak or read English.

An additional issue relevant to transportation is fear. Joseph (2018) describes the experience of an unauthorized im/migrant woman on her way to the clinic who decided to turn her vehicle around when she saw police. Even if an im/migrant has the means to get to a clinic, “the route is not always safe, posing a deportation risk if im/migrant patients are pulled over and detained or arrested by local [or federal] law enforcement” (ibid, p. 89). The violence of uncertainty, and the violence of deportation efforts, pushes im/migrants to not seek—travel to—care. Jenco (2020) terms this as a “chilling effect;” a paralysis of action.

Competing Cultural Practices

Im/migrants come from parts of the world where concepts of health, illness, and treatment may differ from those used by biomedical providers. To put it simply, the medical systems and accompanying practices within which im/migrants are familiar

differ from that used by the U.S. biomedical system. Consequently, as Kirmayer (2004) describes, “the cultural diversity of healing” is a prominent factor U.S. providers should acknowledge and accommodate. Kirmayer (2004, p. 34) states, “Healing involves a basic logic of transformation from sickness to wellness that is enacted through culturally salient metaphorical actions.” These “metaphorical actions” are the healing interventions one seeks during illness (i.e. things put into or onto the body, things taken out of the body, the body is physically manipulated, the body is spiritually manipulated through a religious and/or shamanistic ritual or ceremony.) Regardless of the specifics of the act, whether a pill, a ritual, or a song, it is intended to help transform “quality of experience” (ill to well) and “identity” (ailed to healed) (Kirmayer 2004).

However, cultural difference also relates to broader aspects of biomedicine in the U.S. O’Fallon (2005) describes cultural barriers in relation to appointment scheduling, understanding the significance of coverage, and the adopting the notions of chronic disease and preventative care. The health—and medical—system to which an im/migrant adhered in their home country likely differs significantly from the complicated biomedical health system in the U.S. To that end, im/migrants may have incorrect, preconceived notions of the U.S. health system. As O’Fallon (2005) brings to light, “Many [im/migrant] patients expect that a pill or a shot will cure whatever is wrong with them, thinking that, in America, certainly there is medicine to cure everything.” This is certainly not this case, but the medical imaginary—the infinite imagining of biomedical intervention—runs strong amongst im/migrants who think and hope the advanced medicine of the U.S. can cure all (Delvecchio Good 2010).

Rates of Illness and Disease

Pre-migration trauma has a significant effect on the health status and needs of im/migrants. In a scoping review of 181 refugee studies from forty countries, refugees show greater psychological disturbance compared to non-refugee individuals. They showcase higher rates of Post-Traumatic Stress Disorder (PTSD), anxiety disorders, major-depressive disorder, complicated grief disorder (CGD), psychosomatic illnesses, and “crises of existential meaning” (Silove, Ventevogel, and Rees 2017; Steel et al. 2009). However, findings conflict, with one review finding a nine percent prevalence of PTSD and five percent prevalence of major depression symptomatology among refugees (Fazel, Wheeler, and Danesh 2005), and another review finding 30.6 percent prevalence of PTSD and 30.8 percent prevalence of major depression amongst refugees (Steel et al. 2009). Interestingly, studies that are more meticulously conducted and have larger participant sizes determine lower rates of emotional distress amongst refugees (Silove, Ventevogel, and Rees 2017). Moreover, studies have found a mean of seven to fifteen traumatic events experienced per refugee, and as many as twenty-seven percent of forced migrants have reported experiences of torture (Sigvardsson et al. 2016).

In sum, U.S. social structures make im/migrants vulnerable. Violent social structures, xenophobia, and the operations of capitalism which drive inequality needlessly make life harder for im/migrants. Political policies seek to push them to the margins of society, making not just upwards mobility more difficult, but also survival itself. At stake is the livelihood of the entire United States, as im/migrants provide critical forms of labor and pay billions of dollars in income tax.

Moreover, taking into account the migration phases, im/migrants have a myriad of experiences and reasons for moving across borders. They have diverse outlooks, values, and beliefs systems, and often, they require help accessing and receiving care. In terms of the violence subjugated on im/migrants, both presently and historically, hypervigilance and fear may become embodied traits. Memories of trauma and torture, common experiences for refugees and asylum seekers, may creep throughout the mind, affecting the body and rebuilding of life. Taking into account the argument that the health of all results in a stronger nation, protecting the health of im/migrants appears to hold significant purpose.

CHAPTER THREE: METHODS

In this chapter, I detail the specific qualitative research methodologies I used to gather and analyze data. But, I also add how me and others implemented alterations on many fronts in the wake of the SARS-CoV-2 (COVID-19) pandemic. To that end, with full transparency, this was not my originally planned thesis study. I initially planned to explore emotional unwellness and the symbolism of healing objects among East-African refugee men. However, because of the pandemic, I could not get Institutional Review Board (IRB) approval for my project, and I could not conduct the project I had spent eight months developing. I needed to pursue other avenues.

In my academic program at Boston University School of Medicine, all students must take part in a *SLIP* (service learning internship placement) that aligns with their research and career interests. My SLIP site was at [BMC's Immigrant & Refugee Health Center](#) (IRHC). Developed in the past five years, the IRHC serves as “one central point of entry where any immigrant patient can be connected with all of BMC’s medical, mental health, and social services that they need to heal, rebuild, and thrive.” The driving purpose for establishing the center is to diminish the challenges im/migrants of all types face navigating the U.S. medical system, getting connected with services, and receiving quality health care. Through a *medical home model* centered on a comprehensive team-based approach to care delivery, management, and coordination, patients at the IRHC only need to access one clinical point to get connected with the services they require. However, the IRHC is not just about delivering care. As part of a large academic medical center, educating healthcare professions and conducting research in areas of refugee and

im/migrant health are also significant aspects of operations.

One of the research studies in the IRHC is the core competencies research project. Research personnel created the program as a pilot study for the intended development of an ACGME approved continuing medical education (CME) course and a future clinical fellowship in refugee and im/migrant clinical practice at the Boston University School of Medicine and Boston Medical Center.

Because of my interest in refugee and im/migrant health issues, I joined the core competencies study as my internship project. At this time, research staff already designed the study and received Institutional Review Board (IRB) approval through Boston University. As such, other research personnel created the research procedures and had already begun data collection when I became involved. From October 2019 to May 2020, the head of research operations in the IRHC tasked me with coordinating patient recruitment efforts, conducting semi-structured interviews with patients and providers (including gathering informed consent), writing interview memos, collecting demographics, transcribing interviews, and starting the beginning stages of data analysis. To all those ends, I was not planning to take on the core competencies study as my full-time thesis project. The expectation was that I help conduct the study and use my time at the IRHC to develop tacit knowledge, carry out observations, and establish partnerships for designing and then conducting my own original research. All was going well until March 2020. Then COVID-19 struck Boston.

Journal Entry: May 26, 2020

It feels like day 800 of Massachusetts' social distancing protocols, and I'm sick and tired of my room—the same four walls around me, all the time. The surroundings never change. Is this a prison? I reckon it's not, but the ever growing sensation that I'm trapped grows. Not just physically and mentally trapped, but academically trapped. What if this Zoom meeting does not go well? What if I can't assume the core competencies project for my thesis? What if I'm stuck without an IRB approved study? Ah yes, the mentally exhausting and overwhelming 'what if's.' I'm nervous, but I need to focus—be confident. Today I meet with the principal investigators and my academic advisor to discuss my undertaking the core competencies project. This was not what I had planned—changing my thesis project at the point students in my program normally begin data collection. Further, this was not what my advisor or the IRHC leadership had planned either. Life, due to COVID-19, has changed for everyone. I'm trying to keep this in mind, and I'm optimistic we'll all be able to come to an agreement. Perhaps my nerves are a good thing.

As I previously noted, the overarching end-goal of the core competencies project is to create a CME course and clinical fellowship for im/migrant health. This is still the case, meaning the research methods of the core competencies project I lay out will produce two separate products, my thesis and a pilot result for the CME course/fellowship. The aim, therefore, is to produce both an ethnographic product and a curricular plan. To accomplish these goals, data analysis differed between each project, as the aspects of sampling and data collection were already in action when this became my thesis. In this way, both research products are seeking to answer the same research questions: *What does it mean to provide excellent, high-quality clinical care to im/migrant patients? What does it mean for a clinical provider to embody competence for treating im/migrant patients?*

Each research product, my thesis and the CME/fellowship curriculum, will seek to answer these questions in different manners by approaching the research with separate

data analysis methodologies. In the remainder of this chapter, I describe more about how this project became my thesis, how I recruited participants, how I collected and analyzed data, and how the approaches between my thesis and the CME/fellowship curricular plan differ.

SARS-CoV-2: The event that has changed everything

The COVID-19 pandemic halted all Boston University in-person research and limited personnel on all Boston University campuses, including Boston Medical Center (BMC). I was subsequently not only unable to conduct this study as originally designed, but I also lost the opportunities to have poignant, in-person experiences in clinical settings with patients and providers. I had to change research methods so I could conduct the study remotely, and for the rest of this chapter, I will describe the research design, both as originally planned and as altered in the wake of COVID-19.

Research Methods

Research Design and Planning

The purpose of this thesis is to argue what it means to provide excellent, high-quality care to im/migrant patients. To do this, the IRHC research staff determined semi-structured qualitative interviews with a range of experts and stakeholders in im/migrant health at Boston Medical Center and in the greater Boston community to be the most appropriate data collection methods. Survey data would not suffice nor provide the richness, depth, and nuance that interview data could deliver in comparison. The aim, therefore, was to ask broad, open-ended questions that allowed participants to provide personal and subjective responses.

I gathered data from two different study populations, patients and providers. The rationale is that both im/migrants themselves and the medical and social professionals that treat them have insights that can answer questions about what competence in im/migrant and refugee health should look like. With that in mind, taking into account dissimilarities in medical enculturation across im/migrant patients and the providers that assist them informed the decision to interview both groups, and not one over the other. Medical anthropologist Arthur Kleinman considers this a difference in “clinical reality” — “the webs of cultural and personal beliefs and values within which sickness is organized as a human experience” (Kleinman 1981, p. 161).

Putting this another way, medical school training and post-graduate residencies and fellowships enculturate—condition—healthcare providers to think of medicine, health, the body, and disease in a distinct, cultural way. In converse, the sociocultural upbringings across borders may enculturate im/migrants to think of such aspects of health and illness differently. The clinical realities of American trained healthcare providers and the im/migrant patients they treat clash. Therefore, it was important to explore the perspectives of both groups—the individuals receiving healthcare services, and the individuals who provide healthcare services.

In response, the study included two sets of interview guides and informed consent forms, and I used different recruitment and sampling methods for each study population. The Boston University Institutional Review Board for human subjects research reviewed and approved all research protocols for both studies.

Inclusion Criteria, Sampling, and Recruitment

Patients

The inclusion criteria for the patient study group was purposefully broad, mainly for practicality. The goal was to be inclusive of all im/migrant types, but also narrow enough that the scope of patients' encounters with providers includes those at BMC clinics. In response, all im/migrant patients who had migrated to the U.S. from outside the fifty U.S. states and had received a service from BMC within the past year at the date of study recruitment were eligible for participation. We did not, however, permit individuals under eighteen-years-old to avoid additional and timely IRB protocols when conducting research with minors. That said, as this is a pilot study, the rationale is that the IRHC can conduct a similar research project inclusive of im/migrant youths in the future.

In addition, only English speaking im/migrant patients were permitted, as funding limitations were not flexible enough to pay interpreters. This was not a decision the IRHC leadership made lightly, and I and the staff of the IRHC understand how this limits the research. Requiring such linguistic ability negated the participation of a high percentage of im/migrant patients with valuable insight. However, from a logistical lens, this resulted in some positives. English speaking participants made it easier for coordinating and communicating during interviews, as well as transcribing audio recordings.

Overall, there were four inclusion criteria for patients: 1) Is an im/migrant to the United States/Was not born in the fifty United States; 2) Eighteen years and older; 3) Has

received a medical, clinical or social services from Boston Medical Center within the past one year; and 4) Speaks English.

Patient Sampling

The sampling method for the patient group was a form of convenience sampling, which is common for pilot studies (Salkind 2010). This means we permitted any patient who wanted to take part and met inclusion criteria until the sample data reached saturation and became repetitive. There was no stratifying for age, gender, type of immigration status, or otherwise. The IRHC rationalized they can do this in a future study. There was a limit set at forty patients. In qualitative research, the principle of theoretical saturation, which is the point one hears the same themes consistently repeated, drives the sample size. In general, it is difficult to predict the sample size ahead of time, though, in qualitative research, theoretical saturation is typically met after approximately 30-60 participants. So, we established the maximum as forty.

Patient Recruitment

I recruited patients through a gate-keeper organization, which means another person conducted the initial ask about research participation. In this case, the gate-keepers were the healthcare providers at BMC that im/migrant patients saw for medical or social services. The rationale is that healthcare providers, “by virtue of their personal or work relationship to a respondent” (Lavrakas 2020), were better prepared to approach and ask potential participants compared to me because of an already established rapport. The trust and relationship a provider had established with their im/migrant patients put the recruitment event in a familiar and protective interpersonal space that minimized

coercion and/or pressure to participate. Further, because the principal investigators contacted some providers for both gate-keeping and for an interview, I recruited and interviewed patients after their own provider interviewed. The reasoning was that providers doing the gate-keeping could conduct their interview and then refer patients or other providers over time. Moreover, having providers initially ask patients to participate also allowed for a wider net of recruitment sources compared to just me.

I sampled gate-keeper providers for patient recruitment purposively, through an attending in the IRHC. This attending emailed specific colleagues of theirs at BMC who provide a medical or social service to im/migrants asking whether they would be comfortable interviewing for the study and recruiting patients who met our inclusion criteria. If the provider agreed, I would email them the details of the study, in addition to the patient study information sheet for sharing with their patients. By and large, the biggest hurdle was getting providers to remember to ask. Much of the time, asking patients about participating in this study was not at the forefront of providers' minds. Clinical schedules are incredibly busy, and there are often already enough matters to discuss in fifteen-minute medical encounters. To overcome this, I would send reminder emails to gate-keeper providers the day before their established clinic times. To add, to make coordinating with providers easier and to offer yet another form of a reminder about asking their patients, there were multiple times I attended clinic and waited for any newly recruited patients. But this did not last because of COVID-19, and further, because of the transition to remote appointments and the added stress the pandemic has caused the

U.S. health system and society at large, asking patients about participating in the study was not a priority for providers.

When a patient agreed to participate in the study after being asked by their provider, I would meet them in person if I was in the clinic, or the provider would send me their contact information. In either case, after I received a study referral from a provider and made first-contact with a patient, I answered any questions they had and confirmed they met inclusion criteria. If all went well and the patient met criteria and was still interested in participating, I would schedule an interview and ensure they had a study information sheet.

To briefly add, there was also an attempt to recruit patients via tabling during IRHC clinic times. The idea was to create flyers for the study and sit at a table in the lobby area near where patients sit and enter the clinic. I created an IRB approved flyer and I set times to recruit in the clinic. A week later, COVID-19 hit and BMC suspended all in-clinic operations. As such, this recruiting method never came to fruition, but I added it to the patient IRB protocol.

Providers

We set the inclusion criteria for the provider group in a way that allowed for gathering data about the social dynamics of im/migrants' experiences. There are a multitude of different medical and social services im/migrants access relative to the medical and social problems they face, such as legal immigration help, mental health infectious disease, and women's health services, and more. As a result, the goal was to set the provider inclusion criteria so there was enough breadth to account for service

providers across many clinical specialties. Therefore, in terms of the provider study group, I use the term *provider* loosely. It is not just doctors, nurse-practitioners, and physician-assistants, but any professional or paraprofessional that an im/migrant may come in contact with when accessing medical or social services, such as lawyers, medical assistants, patient navigators, community health workers, interpreters, or otherwise. All the professionals that interact with im/migrant patients have different conceptualizations of what im/migrant care should be—they have varying medical and sociocultural enculturations (i.e., lifeworlds and clinical realities)—not only from their professional training but also their personal lives. So, all types of providers had the opportunity to express their opinions and perspectives about how care for im/migrant patients should be delivered and managed.

Overall, there were three inclusion criteria for providers: 1) Currently provides a medical, clinical, or social service to im/migrant patients at Boston Medical Center or in the greater Boston area; 2) eighteen years and older; and 3) Speaks English.

We sampled and recruited the provider study group purposively through an email script sent by the IRHC attending physician to members in their colleague network. In that regard, there were already a handful of individuals in mind for me to interview based the attending's colleague network. To add, we also recruited providers through snowballing. This means I asked provider interviewees for suggestions of other people, patient or provider, to speak with. The rationale for adding the snowball method was to tap into the network of im/migrant health providers in Boston and locate previously unknown provider professionals and patients of research value.

When a provider agreed to participate in the study, I would receive notice from the attending physician in the IRHC. The attending would add me to an existing email chain between them and the provider participant. I would then email the provider myself to answer questions, set up a date and time for an interview, and send a study-information sheet.

Data Collection

There were two primary forms of data collection methods used in this study, semi-structured qualitative interviews and participant observation. I used both methods in the same manner for both study groups.

Semi-Structured Interviews

IRB approved interview guides (see appendix) helped progress and steer the direction of interviews, but also allowed for flexibility in participant responses. I discussed pre-established topics of research inquiry, but I could also probe for additional topics when mentioned by participants. This allowed me to get the qualitative data I wanted going into the interview, while also giving participants the opportunity to mention and discuss other topics of importance to them. The interview topics across both patients and providers were similar by design, allowing for close exploration of differences in responses between groups. As such, this is the primary means of investigating differences in medical enculturation—clinical reality—between im/migrant patients and their providers. Asking about similar topics while distinguishing non-shared themes across patient and provider responses exhibits where incongruences emerge.

We determined interview topics through an extensive literature review conducted by current Boston University medical students and a former, now graduated, BU master's in public health student. We combined this literature review data with the wide-ranging knowledge of im/migrant health issues of the two principal investigators who originally proposed the study—the head of research operations at the IRHC and an attending physician in the IRHC. In this sense, peer reviewed data and first-hand observations and experiences came together to inform which topics to include in the interview guides.

Interview topics for patients included prompts such as safety and comfort during provider interactions, barriers and facilitators to care, *good* and *bad* experiences in health care settings, desired and needed services, suggestions and improvements for care, highest priority health concerns, and more. The goal was to explore what im/migrants want their care to look and feel like—how they literally want to be medically treated. We complemented this with explorations of patient participants' prior experiences in healthcare settings, both pre and post im/migration, to discern what they perceived to be agreeable and disagreeable healthcare practices.

As noted earlier, this was not my intended thesis study. After COVID-19 created too many barriers to conduct the study I was planning, I had to make last minute decisions. On May 26, 2020, I met with my advisor and the personnel who designed and proposed this research to decide whether I could take on the core competencies project as my thesis. After careful deliberation, and concessions on both sides, they permitted me to carry out this project as my thesis. At that juncture, we agreed I could add some topics from my original study and of my personal interest to the interview guides. I made no

IRB amendment due to the study's IRB exempt status—my changes did not alter the ethical risks of the study. Provider interviews had concluded by that time, so I only added my interview topics to the patient interview guides.

My previous study was phenomenological in design and sought to examine aspects of decision-making, rationality, and symbolism. I was specifically interested in how symbolic perceptions of both traditional and biomedical medications for emotional unwellness affect care seeking and treatment outcomes. To gain insight into some of these areas, I added multiple interview probes, such as pathways to wellness, considerations when making healthcare decisions, the use of traditional and alternative healing modalities, and social stressors that cause or exacerbate illness. The hope was to fulfill some of the research interests I had established in my prior study within the confines of this project.

I asked providers about these same sorts of topics, but there were additional topics introduced in provider interviews, such as cultural humility, importance of legal knowledge and training, current strategies used to overcome challenges with im/migrant patients, information needed before treating im/migrant patients, and most fulfilling experiences working in im/migrant health. These questions sought to inquire about existing practices and methods the provider uses in their professional life, along with where they see areas of need. So, we investigated two overarching domains, the social and clinical—considering both what happens inside healthcare settings and what goes on beyond healthcare settings.

I did not require participants to answer a question if they did not want to, and there were a few times patients felt uncomfortable sharing information on certain matters. I assured them they had every right not to answer, and I moved on to other topics of inquiry.

The IRB approved both in person and telephone interviews with participants. The rationale for having multiple interview options was to give im/migrant patients the option to choose what was most comfortable for them. Further, this also allowed for flexibility when scheduling provider interviews, as determining a time and place to meet in person across my student schedule and their provider schedule became a troublesome task.

When a patient decided they wanted to conduct the interview in person, it would take place in a designated interview room on the BMC campus. I would text the patient the address, as well as the agreed upon date and time (through a Google Voice phone number). I would also send a text or email to patients the day prior to an interview for confirmation.

For in-person provider interviews, I would often conduct the interview in their office. However, there were some interviews I conducted that were in other clinical spaces, such as empty conference rooms which had the same level of privacy. In general, the provider mainly determined where they held their interview. When either a provider or patient wanted to conduct the interview over the phone, I either emailed or texted them the study information sheet so they had it in their possession for the phone call.

Interview Consent and Confidentiality

The IRB protocols for both study groups received exempt study status. This means that the IRB determined the study to pose “minimal risk” to study participants because it fell into the “exempt category” of anonymous interviews. As a result, confidentiality was of the utmost importance across all participants. I did not keep a *master code* of participant names and their coinciding study ID’s, and I redacted any names from interview transcripts. Overall, there are no research materials that can connect a participant to any single individual.

I obtained informed consent from participants using an exempt study information sheet (see appendix) prior to conducting interviews, whether in person or over the phone. The exempt sheet described the purpose of the study, the potential topics discussed, and the means of ensuring confidentiality and anonymity. To add, the sheet also stated that interviews were only to be audio-recorded with participant permission. I would go through the form with the participant, asking if they had any questions or concerns about the study. If the participant wanted to move forward with the interview, I would confirm their consent to be audio-recorded. If they did not consent to audio-recording, the interview would have proceeded without it, but this never occurred.

By the time COVID-19 forced BU to suspend human-subject research, provider interviews were just wrapping up, and I conducted all but one in-person. However, I was only able to interview three patient participants prior to COVID-19 striking Boston. As a result, I conducted the remaining ten patient interviews over telephone once the Boston University IRB permitted remote research methods in May 2020. After receiving a

remote referral and receiving the patient's contact information, I would call the patient through my Google Voice number, set up a date and time for an interview, and text or email them the subject information sheet. At the time of the interview, we would read the exempt information sheet/consent form together over the telephone.

Demographics

Prior to every interview, no matter patient or provider, I collected demographics. However, participants had the option not to share this information. The patient group and the provider group each had different criteria, and we wrote the questions to prompt a free-response. The purpose of taking demographics was to gather additional data about participants and to explore whether any patterns emerged. Examples of provider demographics included: What is your clinical specialty? What is your role for caring for or providing services for im/migrant patients? How long have you been working with im/migrant populations? For the patient study group, questions included asking about age, gender, country of origin, ethnic or tribal belonging, and amount of time lived in the United States. I stored all demographics onto RedCap, a secure web platform for building and managing research data.

I spoke with thirteen patients and thirteen providers. The patient demographics included countries of origin from Algeria, Gambia, Haiti, Jamaica, Nigeria, Puerto Rico, Somalia, Spain, Tibet, and Uganda. The mean age was forty-seven years old with an average time in the U.S. of fourteen years. Eight participants were female, while five were male. We did not ask patients how they arrived in the U.S., but most patients shared their status and form of entry throughout interviews. Eleven patients arrived in the U.S.

as either a refugee, asylum seeker, or unauthorized im/migrant. The other two arrived through student and work visas and a B-2 visa for medical treatment.

Provider participants came from a wide-range of professions, including primary care, family medicine, and internal medicine physicians and nurse-practitioners, pediatricians, women's health providers, social workers, an anthropologist, an immigration attorney, and a legal navigator. The average amount of experience working with im/migrant populations was sixteen years, and eight out thirteen provider participants had completed a specific training, course, and/or certification related to im/migrant health.

Compensation

We compensated patients with a \$20 ClinCard, whereas providers were not monetarily compensated. A ClinCard is a pre-loaded debit card used in research studies as a replacement for cash or gift cards. At BMC, it is the required form of compensating research participants. After interviewing, I would add the patient to the ClinCard database and request an approval for payment. This request went to the head of research operations at the IRHC for approval.

However, in order to submit a request for ClinCard payment, patient participants were required to provide their date of birth and address. In response, I would inform patients of this prior to an interview so that I would not conduct an interview without the proper consent for distributing compensation. When I interviewed a patient in person, I dispersed the ClinCard at that time. Ehen interviews transitioned to telephone after COVID-19, I mailed ClinCards to the patient's home addresses via USPS. I did not save

any of the personal information patients provided and I shredded handwritten notes of such.

Participant Observation

As described by Dewalt and Dewalt (2010), participant observation is a research technique where the researcher critically observes their research population. In most circumstances, this observation takes place in established settings, and the goal is to consider all observances to develop a better understanding of how participants operate in their social worlds. “Observation thus consists of gathering impressions of the surrounding world through all relevant human faculties [...] seeing as much as possible in any situation” (Dewalt and Dewalt 2010). It is not just visual stimuli, but smells, sounds, and personal feelings. It is about questioning everything, noting everything, and then reflecting upon everything one has experienced and observed. Nothing is off limits and the point is to challenge one’s own perspectives about human behaviors.

For my thesis and the development of the CME/fellowship curricular plan, participant observation took two forms: observing the lived environments im/migrants live within in Boston and observing clinical precepting sessions with attending and resident physicians in the IRHC. Because of COVID-19, participant observation was an arduous task, as interacting in public settings became almost impossible during social distancing protocols. Once the Massachusetts state government lifted some policies, I took walks in a few Boston neighborhoods where im/migrants live in high concentrations, such as Roxbury, Dorchester, and Allston/Brighton. My intent was to observe what the areas looked like and what life might be like living in such places. As a

resident of Allston/Brighton myself, this is where I took most of my community field notes.

For participant observations during clinical precepting, I observed in clinic one time prior to COVID-19. The rest of these participant observation sessions took place over Zoom video conferencing. As such, much observing took place on my computer from the confines of my bedroom. Precepting comprises residents reviewing their medical encounters with the attending physicians. The resident first speaks to their patient over telephone (first half of the appointment), they return to meet with the attending to assess next steps, and then they call the patient back (second half of the appointment). When this took place over Zoom (as it partly does now), residents would have a remote appointment away from Zoom with their patient and then return to the meeting to discuss with the attending. I would be on this Zoom call with my audio and video turned off, and I would silently observe and take notes as they discussed the medical encounters and clinical next steps. These observations were invaluable, as they gave me first-hand opportunities to observe how care for im/migrants is delivered from the clinical side. I saw and heard how providers at multiple levels of the clinical hierarchy discuss and treat im/migrant patients. Beyond that, clinical leadership also uses these sessions for formal trainings, which I also observed.

Data Analysis

I transcribed all interviews on the software ExpressScribe, which were verbatim and included emotional inflections when apparent. Afterwards, I saved transcripts on a secure folder and deleted the audio recording. However, the transcriptions were not

perfect, and audio recordings were not of the best quality after I had to conduct all interviews remotely over the telephone. Further, the accents of patient participants created another barrier for clearly hearing their responses. Hence, I transcribed to the best of my ability.

After transcribing, I analyzed interviews in NVivo, a qualitative coding software. Qualitative coding means reading interviews, selecting content, and producing a *code* that denotes the relevance of the data. “A code in qualitative inquiry is most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data” (Saldana 2008, p. 3). In simplest terms, the goal is to summarize, condense, and reduce data to short coded statements. There are different qualitative coding/analysis methodologies, and for the two study populations of patients and providers, we used different data analysis and coding methods.

Additionally, there were also separate codebooks for the CME course and my thesis. To create the CME codebook, for the purpose of establishing inter-coder reliability, I coded collaboratively with a coding partner from the IRHC. This meant that both me and my coding partner discussed the coding of content prior to deciding on creating codes. We read interviews and created codes individually, and then we met to discuss our codes (on Zoom) to create shared codebooks. That said, to write my thesis, I also coded solo and developed separate codebooks. These codebooks were similar and formed partly in conjunction with the CME/fellowship codebooks, but I created my personal codebooks on my own volition. In sum, there were four total codebooks, one set

(patients and providers) for the CME/fellowship curriculum and one set (patients and providers) for my thesis project.

Providers

We coded provider interviews first, as these interviews concluded before patients and allowed for data analysis to occur while still collecting data. This helped to inform interview probing for future interviews. The primary qualitative data analysis method was a form of *content analysis*. Content analysis calls for determining a priori categories for codes to fall into; the researcher may already have a list of categories or they may read through each transcript and let the categories emerge from the data. The provider codebook was built around the ACGME core competencies. My coding partner and I started with the seven ACGME core competencies as initial parent codes, and as we coded, we later fit codes from the data into these domains as daughter codes.

Patients

A significant piece of consideration for the IRHC faculty is that the ACGME and im/migrant patients may have different definitions of what it means to be a competent healthcare provider. This does not mean, however, that one cannot fashion patient perceptions to address the ACGME competencies—this is at the core of my thesis and the CME/fellowship data analysis methods. While the ACGME ascribes qualities, skills, and practices where a provider must exhibit proficiency, these are also refashioned across fields of medicine depending on patient needs and the area of specialty (this was a decision made by BMS IRHC faculty). As a result, the patient codebook did not use the ACGME core competencies as a priori parent codes.

Rather, data analysis for patient interviews consisted of open coding and thematic coding. Putting this another way, we let patients inform us what the core competencies for im/migrant health clinical practice are. My coding partner and I did not try to fit their responses into the bounds of the ACGME competencies, but permit them to tell us what care should look like and entail. As such, we did not use a priori codes as we did with provider coding. That said, patient coding became structured over time as themes emerged.

CHAPTER FOUR: STRUCTURAL COMPETENCE

Bernard's Story

Like the rest of my patient-participants following COVID-19 safety precautions, I could not see Bernard in person. I could only hear his voice over the speaker of my cell phone. I introduce myself and ensure it is Bernard on the other end. The voice in response is croaky, and I have trouble picking up its rough tone. “Yes, this is Bernard,” he says. I am pleased to have little trouble reaching him, and I ask him if he is ready to conduct the interview. Bernard, with his deep, gravelly voice, affirms. His words flow together, likely carrying over from his French-Algerian accent. His thoughts are declamatory—he knows what he wants to say, but few of his words are crisp to my ears. Words and phrases I hear, such as “im/migrant”, “life condition,” “opportunity,” and “problems,” stand out.

I briefly stop him to get informed consent and audio recording permission for the interview, and then he continues. He tells me he is on the verge of homelessness due to an inability to work. The Social Security Administration denied his application for disability, even with an attached note from his surgeon explaining his pathology. “They [Social Security] say that my medical issue couldn’t constitute the reason. Maybe if I die I can get disability!?” says Bernard, bursting into a fit of laughter, perhaps emblematic of his disbelief and continuing struggles to keep his housing and manage his medical problems. He was running into a common problem: How does one pay their rent and bills when simultaneously too ill to work and ineligible for public benefits?

A week after our initial interview, I receive another call from Bernard. Without hesitation, he begins speaking. The slow, modulated pace of his speech from our first

conversation is gone, replaced with a trembling voice and a tone of anger. To make his matters worse, he tells me that amidst trying to acquire disability, he forgot to submit his yearly documents for public housing with the Malden Housing Authority (the municipal housing agency in his community). Apparent is his contempt towards his case manager there, who Bernard says treats him poorly and does not listen to what he has to say. Most of all, he is angry she did not remind him that he needed to reapply for his housing on a yearly basis. He adds that when he sought to handle the matter with her, there was little hope. She said it was too late for him to submit the required income information; he was going to have to leave his home. Rather unprepared for this conversation, I tell Bernard to speak with his doctor's office and request a referral to a social worker and/or housing resources. "I'll call them," he says. Our conversation ends, and I think about his situation. What can he do? Am I even allowed to be helping him?

A few weeks later, I receive a third call from Bernard. He tells me he called his doctor's office but could not get an appointment for a few months. He adds that he called the Malden Housing Authority, again, to no avail. There is worry in Bernard's voice, and I can feel his uncertainty through my phone. At this point, I feel too caught up in the situation to leave him hanging completely. I email Bernard's provider at BMC explaining my knowledge of his situation, and I text Bernard a list of community organizations that conduct housing advocacy. Worried about boundaries and rather unsure of how to help Bernard further, I also inform him I could not help him anymore. The last I heard, he had spoken to a psychologist and contacted Greater Boston Legal Services who put him in touch with a housing advocate.

I continue thinking about Bernard's situation, and I think about why he contacted me for help. The whole situation felt like he was grasping to a life raft, and I felt like the raft. Because of the lack of support Bernard had, I became a new and significant source of help for him. A single researcher who took an interest in his life was now, seemingly, the only person he felt could help. This, in itself, speaks volumes about Bernard's situation. It exemplifies his embodied state of isolation and his necessity to seek help from anyone who seeks to connect with him. Furthermore, his situation and behavior is representative of the struggles im/migrants face and how poor our social structures are set up to promote their wellbeing.

Structural Violence and Structural Competence

The delivery of healthcare services is intimately connected to social inequality. Marginalized people are more vulnerable to illness than those who are not, and it is often up to healthcare workers to help address the repercussions even as the systems in which they operate help produce and further social inequalities. In Bernard's story, while I do not know the original source of his medical issues, the operations of the housing and social security systems hurt his physical and emotional wellbeing. He did not qualify for disability even though he had medical validation, and because he did not adhere to particular application processes, he may have lost his housing. These are all, in one way or another, health issues. Social structures organize society and underpin inequality (Rylko-Bauer and Farmer 2016). This results in poor health outcomes for those forced to live on the margins, and therefore, are an area of critical clinical concern (Farmer et al. 2006); "arrangements are structural because they are embedded in the political and

economic organization of our social world; they are violent because they cause injury to people” (Farmer et al. 2006, p. 1686). Without addressing, or at the minimum, acknowledging the roots of a patient’s suffering from a structural lens, a provider cannot deliver care that is genuinely exceptional (Sklar 2017). And furthermore, one could argue that such exceptional care should be the norm.

As defined by Neff and colleagues (2020) at the Structural Competency Workers Group (SCWG) in Berkeley, California, structural competency refers “to the capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures.” Or, in roughly the same words, structural competency denotes a formulation of clinical practice where health professionals understand and engage with illness as the result of larger social structures and forces. In this chapter, I discuss the concept of structural competency in clinical practice for im/migrant and refugee patients. *Why is a structural approach necessary for providing excellent care to im/migrant patients? How does being structurally competent positively change a patient’s health outcomes and clinical experiences? What does being structurally competent look like in action?* As I seek to answer these questions, my principal argument is simple: a provider who understands how structural factors violently intersect im/migrant patients’ lives is better equipped to treat im/migrant patients than a provider who does not.

On a macro level, structural perspectives help contextualize the causes of illness and stress not only in the lives of individual im/migrant patients but also as phenomena that exist as social patterns that affect im/migrants at-large—immigration as a structural

determinant of health (SDH). As Bourgois and colleagues (2017) contend, this structural framing necessitates “operationalizing structural vulnerability” into clinical training and care—curricula that brings attention to minority patient populations holding a relative risk of developing poor health outcomes due to the arrangement and function of social structures in the United States. In other words, marginalized populations, such as im/migrants, are more vulnerable to the forces of social structures than others, resulting in bodily, social, spiritual and/or emotional harm. In response, this type of structural understanding and clinical approach helps “health care practitioners think more clearly, critically, and practically about the ways social structures make people [im/migrants] sick” (Bourgois et al. 2017) and how “extraclinical stigma, socioeconomic factors, and politics can shape diagnostic and treatment disparities” (Metzl and Roberts 2014)—to embody structural competence.

What are Social Structures

There is no shortage of argument about how we should define social structures. As Mann (1978) writes, social science scholars throughout history have termed social structures as ‘relation between entities,’ ‘principal forms of social organization,’ ‘network of groups, categories, and classes,’ and much more. But social structures have defining qualities; their existence across time concerns social organization and human interaction and arrangement. In simplest terms, humans live and interact in worlds surrounded by institutions and social systems designed to organize, arrange, and control behaviors and actions (Fleetwood 2008). We do not simply go about life uninfluenced by macro-level projects. Rather, social systems and structures, for better or worse, intersect our lives.

In their effort to add description through a lens of health and social justice, Neff and colleagues (2019) describe social structures as “the policies, economic systems, and other institutions (judicial system, schools, hospitals, etc.) that have produced and maintained modern social inequities and health disparities along the lines of social categories such as race, class, gender, sexuality, and ability.” Taking this description into account, at the most basic level, social structures are the overarching systems and institutions that sustain life as we know it. Or, as a scholar who specializes in structural competence told me, they are “the big systems with institutional power behind them.”

Social vs. Structural Determinants of Health

The concept of social determinants of health has gained much traction in public health, clinical medicine, and medical anthropology circles (Artiga and Hinton 2018). As the Centers for Disease Control (CDC) defines them, social determinants of health (SDH) are the “conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes.” That is, our surroundings affect our health. Coming back to Bernard, his housing difficulties, then, would be a social determinant of health. Without a roof over his head, a working stove, heat, or refrigeration, his health would decline. Moreover, as his situation persisted and his options waning, Bernard began to embody states of stress and constant worry. His future hung in the balance, namely in terms of whether or not he would end up on the streets, and his behavior exhibited his diminishing prospects and seemingly future eventuality of homelessness.

Notwithstanding, underpinning SDHs are the social structures that organize our society. In this sense, housing is both a social and structural determinant of health. A provider I spoke with framed it this way, “We all need housing. We either have it or we don’t, and this affects our health. It’s not really a [social] structure, but there are [social] structures that affect who does and does not have housing and how it is or is not working for us.” Housing affects health, but the social structures that make up our housing systems influences why and how it determines health outcomes.

As a result, there is a clear difference between the social stressors causing a patient strife and the social structures that reinforce such stress and determinants of health. Moreover, there are specific structural forces and institutions that target im/migrants. A larger part of Shauna’s story, whom I mention in my introductory chapter, exhibits the particular forms of structural violence im/migrants endure.

Im/migrants and the Fear of ICE

Shauna, as I previously noted, decided to seek care under a false identity because of her initial unauthorized status. This, by itself, represents structural violence because of a lack of healthcare provisions available to unauthorized im/migrants. To that end, even if Shauna did access free care, she could have later faced problems with the public charge rule, which before December 2020 when the Department of Justice withdrew this act of policy, affected future citizenship eligibility if one received public benefits (American Immigration Lawyers Association 2021; Gershon 2018). However, she also told me about a constant fear of being found, a common finding throughout studies with im/migrants in the U.S. (Martinez et al. 2015). Here, Shauna describes what can only be

surmised as embodied fear. Because of violent anti-im/migrant polices, Shauna and many other im/migrants make the embodied decision—express the body intentionality—of avoiding medical care. Just as economists and business managers do, they conduct a risk-benefit analysis relative to the potential dangers of seeking services from hospitals and clinics. Rather than seek out healthcare institutions which may help the body, fear overcomes the pros of potential healing and one makes the conscientious decision to endure life in an ill body which remains hidden in the shadows away from U.S. medical care.

Researchers have termed this im/migrant fear as a “violence of uncertainty” (Grace, Bais, and Roth 2018) and a “chilling effect” (Haley et al. 2020; Jenco 2020). There is no telling if any decision, whether buying groceries, going to the laundromat, taking the kids to the park, or seeking healthcare services will put one at risk of being found and deported. The result is an embodied paralysis—chilling or freezing—of movement, notably in seeking medical care, applying for public benefits, and maintaining sociality. While not new, such im/migrant fear and inaction increased during the Trump administration (Bernstein et al. 2020). As I expand on in chapter five, trust and communication, im/migrants sometimes associate hospitals and clinics with government, so there is a concern that hospitals may have im/migration officials watching and waiting to strike. One provider who conducts research with im/migrant populations told me,

For folks that are undocumented it's, you know, any sort of exposure of their status, you know, is a high risk and I think that causes a great deal of mental and emotional stress that affects the whole family and their ability to function in the world. Always sort of wondering if they will be discovered or deported. So I think living with that fear makes it difficult to believe that official institutions within the society actually care and expose you to, you know, the security apparatus.

The outcome of im/migrants avoiding care is directly related to structural forces targeted at finding and removing im/migrants, and there have been arguments that ICE is solely focused on perpetuating violence in im/migrant lives. Silky Shah (2020), executive director of Detention Watch Network, contends that ICE, because of its history of abuse and criminal tactics, should be abolished. “ICE was created in part to criminalize and target im/migrants for incarceration, deportation, and exclusion from their communities and their families. As such, the agency’s disregard for human life is part of its very foundation and has evolved to create a culture that enables and perpetuates human rights abuses” (Shah 2020). It is clear that U.S. immigration structures and institutions create havoc in im/migrant lives—manifesting stress and a “violence of uncertainty” relative to being found, deported, and living a peaceful life (Grace, Bais, and Roth 2018). Shauna, with her hypervigilance and raging fear of ICE discovering her, is representative of how ICE interjects embodied fear and violence into im/migrant bodies and lives.

Bureaucratic disentanglement

However, the “violence of uncertainty” and the “chilling effect” are not limited to unauthorized im/migrants. The most recent presidential administration ruthlessly targeted im/migrants of all types, authorized or not, enforcing policies that push eligible im/migrants away from applying for services (Barofsky et al. 2020; Grace, Bais, and Roth 2018; Van Natta 2019). Therefore, even when im/migrants are entitled to a service or benefit, they do not apply, “which suggests confusion, fear, and a ‘chilling effect’ whereby even eligible im/migrants are discouraged from applying for or using publicly funded health coverage or services” (Derose, Escarce, and Lurie 2007, p. 1263).

These types of detrimental efforts, operationalized through public policy and bureaucratic actors, function as forms of bureaucratic disenfranchisement, which Danz (2000) describes as “the insidious process by which administrative agencies deprive individuals of their statutory entitlements and infringe on their constitutional rights.” In daily U.S. bureaucracy, “it takes the form of withholding information, providing misinformation, isolating applicants, and requiring extraordinary amounts of documentation for simple administrative procedures” (Castañeda 2019). In other words, bureaucratic actors on the ground and ‘fine print’ in policies and procedures prevent the application and reception of the public services and/or benefits for which im/migrants are rightfully eligible for.

Structural, systematic effects of inequality, then, undermine the survival of marginalized people and their communities through a disenfranchisement to social services that provide crucial forms of socioeconomic support. As for im/migrants, this means problems reading and filling out documents, providing identification, and proving a place of residence, occupation, and income when applying for social services such as housing, insurance coverage, an identification card/driver’s license, or otherwise (Castañeda 2019; Joseph 2018). This only becomes more a problem of disenfranchisement when we consider the other types of structural and acculturative stress im/migrants face as a result of adjusting to a new country (Kuo 2014).

Bernard’s story is a perfect example of an im/migrant experiencing a disenfranchisement to an eligible public benefit. First, despite being disabled and providing information from his doctor to prove the validity of his condition, Social Security denied his application for disability. He was not, from the U.S. government’s perspective, the

right type of disabled; he did not meet the list of “qualified medical impairments” (see here: <https://www.ssa.gov/disability/professionals/bluebook/AdultListings.htm>). Or, rather, he did not meet the status of a “morally legitimate suffering [disabled] body” (Ticktin 2011).

Ticktin, in her book *Casualties of Care*, argues that while we, as humans, consider suffering as universal, its definition is fluid and does not correspond directly to physiological or emotional injury. Instead, “The meaning of suffering and of bodily integrity is mediated by social, political, cultural, and economic contexts and histories” (Ticktin, 2011, p. 4). Certain types of suffering are enough for certain reasons, and the qualities of *morally legitimate suffering* change across context and time. So, while Bernard was disabled to a point that he could not work, his suffering did not meet the moral imperative of assisting the disabled as outlined in the list of qualifying impairments. Thus, the Social Security system disintitiled him to a service he should qualify for. The ramifications were his livelihood and security, putting him in a bind between managing his physical body and the home that protects it. Moreover, this bureaucratic disintitlement further compounded Bernard’s already arduous situation, pushing him to embody states of distress that corresponded with his inability to economically provide for himself and pay his rent.

But his situation became a further form of bureaucratic disintitlement when his housing case manager informed him he lost his public housing. The municipal housing institution in his local area was to take away a public service he was eligible for and already in the process of receiving because he did not submit the required yearly

application and income verification documents. As Castañeda (2019) and Joseph (2018) bring to light, bureaucratic disenfranchisement takes inconspicuous forms, usually related to small nuances while applying for services or obstruction from bureaucratic actors. The ‘fine print’ of yearly applications for housing, as well as the passive action of his case manager, a bureaucrat who informed Bernard of his situation after the fact, resulted in a disenfranchisement to his housing benefits. Subsequently, Bernard was left in a position in which he could not work and was going to lose his housing. There is zero doubt this negatively affected his health and pushed him to further embody states of distress, desolation, and anger. Thinking about what this situation felt like for Bernard, irrefutably in a bind with little options and hope, it is reasonable that Bernard reached out to me—a stranger to him—on numerous occasions, grasping at any possible person who could open a doorway to solving his problems.

Similarly, Shauna, in her decision to seek care under a false identity, was also the subject of bureaucratic disenfranchisement, not just structural violence. Chapter 58, Massachusetts’ Healthcare Reform law, established healthcare provisions for all income-eligible residents regardless of immigration status. As such, Shauna could have received care under her real identity and unauthorized im/migrant status. The reason she decided not to do so is the source of her disenfranchisement. Racism, anti-im/migrant sentiments, and policies create im/migrant fear, and Shauna’s thoughts of being discovered and deported by ICE resulted in decisions to forgo applying for and/or accessing eligible services. “I noticed that one day I was stressing. I just started to get very, very sweaty. My hands were sweaty. I was just shaking, and you know, I was just, I felt like my heart was

racing” Shauna said. “I didn't know what was wrong until I called 911 and I went to the hospital. They told me that it's anxiety, which, it comes from all of that. All of, all of that fear. Wanna go see a doctor, you wanna go do something [makes a grunting noise] [...] If you are in the hospital and you have no papers you just think, you just wonder when the cops coming.” Violent anti-im/migrant health and deportation policies drove Shauna to embodied states of angst and tribulation. Relative to the sociocultural and political world of the U.S. in which Shauna’s body now existed, new “social relations and modes of perception” (Desjarlais and Throop 2011) began to inform her own life, ways of being, and physiological state. Her consciousness and body, oriented to the stress caused by U.S. social structures, began to respond. As Bendixsen (2020, p. 482-483) discusses, Shauna developed an “embodied un/belonging,” which

shows how biopower induces and configures processes of exclusion/inclusion and embodied un/belonging that have detrimental consequences for people’s health and well-being. Irregular migrants’ experiences of being stigmatized in the public sphere (by the media and politicians) and of social exclusion come to characterize their understanding of encounters with healthcare institutions and generate a form of embodied unbelonging.

For many im/migrants, the result of this social “unbelonging” is the embodied decision to avoid healthcare institutions and refrain from full participation in society. Similar to Williams and Orrom’s (2014) concept of “structures of feeling,” anti-im/migrant rhetoric and policies drove Shauna to feel as if she does not belong in the U.S., and over time these feelings altered her decision-making. Social structures, while non-living entities that cannot feel emotion, elicit strong emotional and embodied responses in the human lives they affect. For Shauna and many other im/migrants, whether authorized or not, the feeling is that one does not belong and that such

unbelonging comes with profound marginalization, risk, and punishment. In turn, the “bodily intentionality” of im/migrants changes and one makes decisions that will not put their position within U.S. borders in jeopardy. The balance is between saving the body or protecting where the body exists. Risk is relative. Whereas not seeing the doctor when ill is a risky decision that is detrimental to health and the body, the decision of accessing care could be even more so.

Moreover, Joseph (2018, p. 88) notes, “The standard verification methods [at medical clinics/hospitals] are harmless for most patients but create additional concerns for im/migrant patients, especially the unauthorized, who fear that their use of health services may affect their immigration status.” While eligible to receive subsidized care regardless of her unauthorized status, sociopolitical operations of im/migrant fear—such as deportation and the public charge rule—disentitled Shauna from seeking medical services for a long time. This resulted in the precarious situation of her receiving emergency care under a false identity, which also corresponded with a rising blood pressure providers could not figure out. Not only was her health at risk because of hypertension and socioeconomic stressors, but this also hindered the providers’ abilities to deliver adequate care because of Shauna’s embodied fear of communicating.

Furthermore, this all begs the need for providers to be aware of how public policy, at all levels of government, affects im/migrant patient decision-making. If a patient avoids seeking care for years or declines a benefit or service that would help them, their reasons are not groundless. They directly relate such rationality to anti-im/migrant policies and concerns about one’s future. As a provider I spoke with put it,

Certainly anyone in refugee and im/migrant health has to have a working knowledge of health policy and immigration policy in the U.S. [...] So, the patient who says, 'No, I don't want that service.' or 'No, I don't want that benefit.' Generally, that's going to be confusing to a clinician. 'Why wouldn't you want this service or benefit that could be of assistance to you?' But, if you understand health policy and immigration policy, especially currently, you'll understand that some people may be avoiding benefits because they don't want to have issues with their immigration status later on. So, you have to have, as I said, a working knowledge and an up-to-date working knowledge of all these governmental levels, because patient's concerns are often based on them.

Im/migrants genuinely worry whether the services they access will impact their immigration status. It affects how they engage with the U.S. healthcare system, and resultantly, it affects how providers deliver care. When im/migrant patients feel inclined to refuse interventions because of immigration related trepidation, it severely limits care delivery. But, in terms of sociopolitical policy, such rationale makes sense. Im/migrants are making a sound decision that protects their status on American soil. That said, in the wake of The Justice Department's decision to rescind the public charge rule, these fears can now, in theory, somewhat subside. It is up to providers to educate their im/migrant patients—bestow knowledge capital—as immigration policy changes. That is, staying informed about and understanding how laws, policy, and political discourse affect im/migrant decision making, and then conveying such knowledge to patients.

Socioeconomic stress

However, Shauna and every other patient participant mentioned other socioeconomic stressors in their lives related to finances, employment, education, and kinship. To their point, this brings up the second part of the social determinants of health; while SDHs relate to how our surroundings affect our health, they also relate to the types of social capital we hold. As Bhandari and Yasunobu (2009) define it, social capital is “a

collective asset in the form of shared norms, values, beliefs, trust, networks, social relations, and institutions that facilitate cooperation and collective action for mutual benefits.” This is roughly equivalent to saying that social capital consists of the people who matter to us, who can connect us to other forms of capital, and who can provide us support when we need. However, for the purposes of this thesis, I take this definition further. Rather than just people, social capital refers to the other types of capital that directly affect one’s perceived social worth, such as education level, class, occupation, race, ethnicity, immigration status, primary language, and more. As Pierre Bourdieu writes,

The volume of the social capital possessed by a given agent thus depends on the size of the network of connections he can effectively mobilize and on the volume of the capital (economic, cultural or symbolic) possessed in his own right by each of those to whom he is connected. This means that, although it is relatively irreducible to the economic and cultural capital possessed by a given agent, or even by the whole set of agents to whom he is connected, social capital is never completely independent of it because the exchanges instituting mutual acknowledgment presuppose the reacknowledgment of a minimum of objective homogeneity, and because it exerts a multiplier effect on the capital he possesses in his own right (Bourdieu 1986, p. 21).

In other words, the concept of capital is not simply about who is part of our personal milieu and the potential these relationships hold. It also concerns how the qualities and identities we bear have perceived and direct value—capital—in terms of upward, or social mobility across U.S. society. It is not merely about who we know, but also the sociocultural assets one holds (Bourdieu 1986).

For example, safe housing is a social (and structural) determinant of health, but one’s occupation and education level will affect the type of housing one has, food security, access to transportation, healthcare coverage, and more. To provide another

example specific to im/migrants, healthcare coverage is granted to refugees upon resettlement in the U.S., at least for the first 8-months, through federally funded Refugee Medical Assistance. Comparatively, unauthorized im/migrants (in states/territories other than California, Illinois, Massachusetts, New York, Oregon, Washington, and The District of Columbia) are not eligible for state-sponsored coverage (Salami 2017). Here, politically informed im/migrant identity affects the capital—specifically healthcare coverage eligibility—one has. That said, unauthorized im/migrants in states where they are eligible for healthcare coverage, receive much less coverage options compare to authorized im/migrants and U.S. citizens. This further supports the notion that certain identities relative to law, policy, and sociocultural and economic beliefs informs the social capital one holds.

Therefore, “The truth of the matter is that no one is invulnerable. All people have vulnerabilities [...] The difference is that some people have resources they can use to address situations in which the vulnerabilities have manifested themselves in illness” (Sklar 2017). Social factors that determine health are intimately interconnected to one’s capabilities of managing and responding to them. Im/migrants, who often experience under/unemployed (Batalova, Fix, and Bachmeier 2016) and face unique forms of social stratification such as bureaucratic disenfranchisement, the concept of various forms of capital relative to constraint and capability is of significant importance (Bourdieu 1986). They directly connect to one’s embodied states and feelings. A lack of capital, whether in terms of social network capital, the cultural capital of education, or otherwise, affects the lived reality and condition of our individual lives. Im/migrants, as they adjust to new

surroundings and seek to construct and attain new forms of capital, may face tremendous barriers that oppose survival and upwards mobility. This, in turn, can result in both embodied dolor, a sadness oriented towards thoughts of loss, trauma, and social obstructions (Crocker 2015), or embodied intrepidity, a strong desire to overcome obstacles and rebuild despite the forces of structural violence (Besteman 2016; Piwowarczyk, Flinton, and Ona 2019).

Belief Systems and Social Structure(s)

Furthermore, on a deeper societal level, upward mobility and survival are also directly connected to racism, xenophobia, and other types of social discrimination. Such negative belief systems have marginalized and oppressed minority communities for generations, subsequently affecting their socioeconomic status (Chetty et al. 2020).

In response, these structurally ingrained problems necessitate revisiting the latter half of Neff and colleagues (2020) at the Structural Competency Workers Group's description of social structures: "Modern social inequities as well as health disparities [are] often along the lines of social categories such as race, class, gender, sexuality, and ability." Such categorizations are intimately connected to discriminatory belief systems that put people on a continuum of privilege. Taking a historical look at the founders of our nation, they were privileged, white, heterosexual, Christian males (Fredrickson 2015). Other social groups and identities, such as women, African Americans, Native Americans, Jews, Muslims, Asians, Latinx, im/migrants, LGBTQ+, disabled, and other groups who have historically been minorities in the U.S. fall lower on the social continuum, with their positioning dependent upon changing societal perceptions of

deservingness and animus (Crenshaw 1991). As Foucault's (2008) and Mbembe's (2001) theories of biopolitics and necropolitics posit, the state—or whatever entity holds power—both nurtures and harms certain lives across time. “The ultimate expression of sovereignty resides, to a large degree, in the power and the capacity to dictate who may live and who must die” (Mbembé and Meintjes 2003, p. 11).

The point is that social structures are operationally informed through belief systems of right vs wrong, beneficial vs detrimental, worthy vs undeserving, etc., and moreover, they influence why the state and some U.S. citizens treat im/migrants negatively. One story a provider shared is particularly emblematic of the pervasive discriminatory beliefs systems across the United States that affect im/migrants.

I had a family where the older girl, who is now in college, but when she was in 10th grade, she told me this was like in 2017, I guess right after the election. She told me her 'friends' from her high school were walking her to the Dudley Square MBTA (bus) station. She was getting harassed because she was wearing a hijab. So those were her 'friends' from schools doing that to her. Of course she was having migraines, she wasn't sleeping, she felt really stressed and I just saw that same family last week. And one of her younger sisters who is now in 5th grade is being bullied in school because she is wearing a hijab.

Im/migrants and those who hold other minority identities are more vulnerable to hateful rhetoric and belief systems. As a result, their lives become a delicate balance between determining capable agency amidst belief systems, social structures and government policies designed to harm them (Chen and Hulsbrink 2019; Bourgois et al. 2017; Quesada, Hart, and Bourgois 2011). In the terminology of Parin Dossa (2009) U.S. im/migrants and other minorities live in “disabling worlds [...] where one is subjected to social erasure in policy.”

Through this “erasure,” dishearteningly, comes the naturalization of structural

violence, or the unconscious acceptance that some people are more prone to violence, suffering, and disparity than others (Burawoy 2019; Neff et al. 2020; Morgan and Björkert 2006). Consequently, we see structural vulnerability and social disability as normal, and we conceptualize the roots of suffering and inequality as the “natural order of things” (Bourgois and Schonberg 2009, p. 33). This is what Bourdieu terms as *symbolic violence*, where “inequalities are made to appear commonsensical, and they reproduce themselves preconsciously in the ontological categories shared within classes and within social groups in any given society” (Bourgois and Schonberg 2009, p. 33).

Symbolically, we perceive structural violence as ordinary phenomena and attach myths that disparage the marginalized and shift blame to individual decision-making. Further, this blaming is falsely associated with negative attributes and behaviors about people considered The Other, resulting in a “weaponizing stigma” based on sociocultural differences (Scambler 2018). “Such naturalization causes the social origins of health disparities and structural violence to be de-emphasized or overlooked entirely” (Neff et al. 2020). For the white hegemony, this means an embodied ignorance of social inequality and the disparaging operations of policy and social structures actively marginalizing minority populations. The obverse, for im/migrants and other populations who experience forms of structural violence, whether or not they perceive social inequality as naturalized, are embodied feelings and states of fear, unbelonging, struggle, and difference. They experience inequality as lived reality, and for better or worse, effects one’s “bodily intentionality” and becomes part of who they are on a daily basis.

The end result, as one provider told me, is “a compounding vulnerability,” which

refers to the many factors that add to the vulnerable status of im/migrant patients both domestic and abroad. This is roughly the same as saying there are layers to suffering, and that there are many stressors—pain points—present in an im/migrant’s life at the same time. Suffering, then, becomes chronic. There is no post, but rather hardened and continuous experiences of pain and struggle. The provider above continued to say, “Vulnerability. Being wounded and tortured from another country, separated from your family and your friends and children and everything. Vulnerability of socioeconomic levels from your country then over here again.” Being made vulnerable, as this provider points out, never stops for im/migrants.

Structural Vulnerability and Social Determinants of Health (SDH) Screening

Almost every patient participant mentioned that providers should ask about the types of socioeconomic problems in their lives. Beatrice, having dealt with constant social stressors throughout most of her life, gives providers a list of questions that could be helpful to ask their patients. *“Are you working? Do you feel comfortable with your current job and where you are working? How are the conditions of your housing? Do you have problems with your landlord? Do you have enough food in your house to eat? What can I do to help?”* Akin to a social vulnerability screening assessment tool Bourgois and colleagues (2017) designed, these types of questions address the social stressors im/migrants may face. The tool suggests questions across eight social domains intimately connected to the social inequality and health disparities: *financial security, residence, risk environments, food access, social network, legal status, education, and discrimination.*

Bourgois and colleagues (2017, p. 10) state, “Our tool is a strategic practical heuristic mechanism designed to promote an understanding of how social conditions and practical logistics can undermine the capacities of patients to access health care, adhere to treatment, and modify lifestyles successfully.” Rather than examine and treat patient complaints from solely a biological lens, this social vulnerability tool brings to focus the root social causes of a patient’s illness and distress. Their point is that while our bodies hold our pain and suffering, the causes and solutions are socially situated. Of the thirty-plus questions they recommend, particular examples include: “Do you have a safe, stable place to sleep and store your possessions? Do the places where you spend your time each day feel safe and healthy? Do you have any legal problems...Are you scared of getting in trouble because of your legal status?” As such, the goal is to contextualize the patient’s social positioning, or “produce one’s [the patient’s] location in a hierarchical social order” whereby social vulnerabilities come to light (Bourgois et al. 2017, p. 4). By doing so, Shauna’s emergency room and hospital providers, that is, if Shauna answered their questions, might have learned that she moves between friend’s couches and the street. They might have discovered that she has no family in the U.S. and struggles with anxiety, hypervigilance, and isolation. They might have found that she cannot find steady work and that physical labor has exacerbated a spinal injury, preventing her from collecting a consistent income. They might have figured out that she was in the hospital under a false identity and that her hypertension was the result of an intense fear of deportation related to her unauthorized status.

There are simply endless possibilities that relate to the health and wellness of

im/migrant patients, and often the only way to assess social needs and stressors is through patient engagement and question asking. The catch, however, with Bourgois and colleagues' (2017) questionnaire is a lack of time and systemic constraints when delivering care. Whether during an emergency room visit or fifteen-minute appointment, a provider simply does not have the time flexibility to go through thirty individual questions. As a provider shared with me,

The time constraints that are involved, and the clicking buttons and the endless amounts of administrative things that have to happen during the visit [...] I feel like we could do a better job if we had more time. To actually have the type of conversations we really need to have to really understand what the patient is experiencing and what they are going through and what they really see as their own barriers.

In other words, systemic constraints and administrative burdens encumber tools that help providers connect with patients and understand their social needs and positioning. Providers have to manage their time in order to see every patient, submit notes, abide by certain codes and practices, and more. In short, there is much more providers have to do beyond the medical encounter that actually communicating with the patient and determining suitable interventions takes a backseat. Delivering exceptional care is still the goal, but the system itself creates barriers by adding additional tasks that do not directly involve or take time away from interacting with a patient.

One possible solution, as the provider above continued to say, is utilizing the “dead time” patients have while waiting to receive care. During these unused times, other providers, such as nurses, medical assistants, or patient navigators could meet with patients before seeing their primary provider. Here, paraprofessionals could ask Bourgois and colleagues' questions and gauge the patient's structural vulnerability, and then relay

information to primary providers before the clinical encounter.

Another option is SDH screeners that patients complete themselves on paper or a computer tablet while waiting. For example, at BMC, clinics use THRIVE, a questionnaire patients complete prior to seeing their provider. “THRIVE strives to understand social needs impacting patients’ health, improve patient care by communicating social needs to care teams, provide patients with information on community resources that can mitigate their social needs and partner with our community to eliminate systemic barriers that prevent patients from *thriving*” (Buitron de la Vega et al. 2019, p. 134). Just as Bourgois and colleagues’ (2017) screener seeks to help providers contextualize the needs of patients, THRIVE does the same. However, rather than squander time during the medical encounter, providers can look at a patient’s responses prior to seeing them, resulting in the ability to understand the patient’s social stressors, prepare follow-up questions, and determine possible solutions even before starting the appointment (Buitron de la Vega et al. 2019).

As the same provider above added, this helps healthcare professionals better connect and communicate with patients, mainly because they do not feel rushed. “I think a doctor who is not super stressed will pay more attention to cues, so they are not stuck staring at their computer [...] Visual cues. Like, you know, is a patient tearing up? Did the patient freeze up when you asked a question? Did they.... I think being able to gauge body language is actually really important to the patient relationship,” For im/migrant patients who often desire human connection with their providers and tangible solutions to their daily strife (see chapter four, Trust and Communication), adding any measure that

helps support empathetic care is crucial. If a provider has their ‘head in the computer’, reading off verbatim questions, unable to see how a patient physically responds, there is immediate detriment to rapport-building. An SDH screener, such as THRIVE, can mitigate these clinical encounter problems by screening prior to appointments, creating better opportunities for providers to use their time with patients wisely. This helps providers remove “negative communicative space” (Buetow 2009) in the clinical encounter, driving human connection through attentiveness and active listening.

Moreover, beyond the potential for better health outcomes, incorporating SDH screeners has financial benefits for providers and hospitals, both directly and indirectly. Directly, SDH screening helps ensure providers get reimbursed for their care. According to Section 3025 of the Affordable Care Act (ACA), the Hospital Readmissions Reduction Program (HRRP), if a Medicare patient with acute myocardial infarction, heart failure, coronary artery bypass graft, total hip and knee arthroscopy, or pneumonia returns to any hospital within thirty days of an emergency room visit and/or admittance to any hospital, Medicare will not pay reimbursements (Gai and Pachamano 2019). The rationale of this ACA policy is to incentivize care coordination and ensure adequate intervention upon discharge, which has worked. As Ferro et al. (2019) found, readmissions have declined after HRRP regardless of the patient’s insurer. It has behooved all clinics, hospitals, and providers to make sure patients’ needs are met after a hospital stay. For im/migrant patients, as I explain with Bernard and Shauna, who deal with problems such as housing insecurity, inability to work, isolation, and fear, healthcare providers accounting for and alleviating social stressors is necessary not only for the patient’s own

wellbeing but also to ensure providers get reimbursed for their time and efforts.

Indirectly, SDH screening also helps reduce healthcare costs as efforts are put towards the root problem(s) of a patient's situation and preventative measures are implemented. The point, here, is that many of the reasons patients seek care are preventable. Screening allows providers to analyze what parts of the patient's life, whether housing problems, food insecurity, unemployment, substance abuse, intimate partner violence, discrimination, or otherwise are causing, prolonging, or exacerbating illness and the need for care. When clinical care and/or public health efforts determine and mitigate such factors that hurt wellbeing, the patient's health improves, reducing healthcare costs across the entire U.S. healthcare system (Bush 2018).

In terms of embodiment, this means improving the daily lived reality in which the body exists. Taking into account Carman Taylor and Merleau-Ponty's (2011) conceptualizations that perceptual awareness relates to the senses and the position of the body within the environment where perception occurs, enhancing the lived environment in which patient's bodies exist can produce favorable health and life outcomes. Our bodies do not exist in vacuum, but sociocultural and environmental spaces that have either beneficial or detrimental effects to wellbeing. Through improving the patient's daily lived environment—the world in which the patient inhabits—care can positively adjust the patient's bodily perceptions and health.

To bring this all together, Zoe, a refugee single mother who was putting herself through nursing school, shared how SDH screening saved her and her kids from becoming homeless. At the time, Zoe's stressors began to mount as the struggle of raising

kids and creating better socioeconomic opportunities for herself and family took a toll.

Zoe: One of the major stressors I've experienced is being a single mother [...] I was in school full-time, and I had a very terrible relationship. So, it was a total of those things and some more. Ties into the fact that I couldn't provide for my children. I couldn't. I was able to concentrate on school, attend fully, but at that time it felt like everything was falling from under my feet and was kind of opening up. So, everything was kind of really tough at that time because I had to not only take care of myself, I had to take care of my kids. I had to go to school. I had to make sure I still have good grades because I was in nursing, and you know how nursing school is. It's very tough! [...] At that time, those were the things that were stressing me out. And coupled with the fact that I couldn't provide basic stuff for them [my kids]. So, those are the things that really stressed me out at that time. And, that's stuff that stresses people out. Not exactly like mine, but life, money, accommodation was a very big one at that time for me, a very big one, that I was almost homeless. Accommodation, food, those are the things that people carry around regardless of how they look. You might not know. In my case, you would never know because I dress up. I look very nice, and nobody knows what was going on with that until I open, I open my mouth and say something, you know what I mean? So, these are the things that I know BMC does. I know they do have a questionnaire that's a very good point for the practitioner or healthcare provider to piggyback off [...] I got my housing through that program from BMC., and I was not homeless. I was this close to being homeless at that time. And I ended up not being homeless."

Zoe's story emphasizes three critical aspects of structurally informed care. First, the only way to understand the patient's struggles is through a form of questioning, either verbally or written. As Zoe says, people suffer regardless of how they look, so there is a need to prompt. Second, efforts to improve one's socioeconomic situation can create massive strain, and as Zoe's story encapsulates, put people in even greater binds as they invest energy towards matters other than making money right now. Zoe could have kept low paying jobs that would have paid the rent and kept some food on the table. However, there would have been little room for upward mobility. So, there is a give and take when an im/migrant decides to go to school, especially when no other breadwinners live in the home.

Third, SDH screening through BMC likely saved Zoe and her family from moving to the streets. Without housing resources for the purpose of intervention, her entire family's health would have declined, and moreover, could have resulted in additional healthcare costs down the line. This is a representative of, as the Structural Competency Workers Group terms it, levels of intervention (Neff et al. 2020). Using the framework of Bronfenbrenner's socio-ecological model, which posits the overlapping of social influences from the micro to the macro (e.g. individual, interpersonal, communal, governmental, etc.), the concept of *levels of intervention* connotes how different therapeutic actions challenge the operations of unjust social structures at different points. Returning to Zoe, for example, the ability of her providers to deliver a housing solution, while an individual level intervention, used network capital (Vallejos et al. 2008) to challenge the socioeconomic systems that put her and her children on the cusp of homelessness. In other words, collaborative efforts (which I discuss further in chapter six) drawn from social capital allowed Zoe's provider to develop a housing intervention.

But even more so, levels of intervention include actions that directly combat structural violence at greater levels, such as community and political advocacy, conducting research, organizing social movements, or writing letters to bureaucrats. The structural violence scholar I spoke with framed it like this, "Ask yourself, what can I do with my powerful positionality as a doctor to oppose the violent social structures in my patients' lives?" Providers, especially doctors and attorneys, possess bodies and minds of great social influence—social and cultural capital—for creating change and establishing valuable collaborative partnerships (Saxena et al. 2019). Advocacy, then, which was a

common emphasis in my observations of resident precepting in the IRHC, is a critical role for healthcare providers. As Thomasson (2014) writes, “Without being advocates for our patients we [doctors] cannot address their health status or their illnesses adequately [...] it is a social responsibility.” Acts of opposition and advocacy, as I explain through Zoe’s story, can range from combating the sharp end of structural violence, such as poverty, hunger, and homelessness, or the blunt end, which are the upstream structural causes of inequality and social suffering.

To all these ends, however, is the requirement to screen for and embody an understanding of structural vulnerability. If providers are not aware of the unjust operations of our social structures, including the U.S. healthcare system, and do not have the means to mitigate and alleviate the detrimental effects of negative social circumstances, especially in terms of im/migrants who may exist at a nexus between racism, xenophobia, and socioeconomic inequality, there is limited room for quality care outcomes. The problems of social life would continue to persist, and so too would the causative factors of illness and rising healthcare costs.

Trauma-Informed Care is Structurally Informed Care: Im/migrant Narratives

Roter and Hall (2006), in their book *Doctors Talking with Patients/patients Talking with Doctors: Improving Communication in Medical Visits*, write “Patients need to feel that their doctors take a personal interest in them as individuals, like them, are concerned and committed to their welfare, and will constantly take pains to do a good job. The fulfillment of the basic need to feel known and understood begins with the telling of the patient’s story” (p. 7). Storytelling is a powerful form of human

communication, and within the realm of healthcare, it can allow patients to give depth to their life experiences and requirements for care. For im/migrants, such storytelling extends to sharing a migration narrative—the reasons, emotions, thoughts, and experiences during the im/migration journey. As Margaret, a refugee patient I spoke with told me, such storytelling is a critical part of treating im/migrants. But, she adds that there are unique nuances when providers elicit im/migrant narratives.

***Margaret:** If an im/migrant tells you how that im/migrant reached here, how their story started there, it needs a doctor to listen. Because, that means it will be a mix of pain and heart of remembering what happened. And the [pause] knowing that 'Now, again, I'm going to tell it again.' That means I'm reminding my brain back home. I'm telling it here. But, 'does this doctor care? Does this doctor know that certain things have happened? Is he kind enough to listen to me?'*

“A mix of pain and heart of remembering what happened.” Im/migrant stories, especially for forced migrants, are imbued with experiences of trauma. The simple act of holding such terrible memories may manifest in illness and often are the gateway to connecting with and understanding what patients’ needs. There is pain when im/migrants re-tell their stories. They are a part of who they are, and so they also appreciate the time a provider takes to listen. As Zoe shared,

***Zoe:** If the person [im/migrant patient] wants to say, tell their story, yeah, that's really, that's very important. That's really important. Yes. It is. If the doctor is able to take their [emphasizes] time to do that. Cause I know that they really very busy. They want to attend to everybody else. But, for them [the provider] to take their time to do that, that's, that's really very that can be really appreciated and make the patient feel at ease and comfortable with the doctor.*

Amidst the hectic schedules that providers deal with, im/migrants truly treasure the additional time taken to hear about their life experiences—how and why they have become an im/migrant. Such listening shows that the provider wants to understand the

intricacies of their life trajectory and connect how the past is affecting their current being.

Moreover, in analyzing the patient's im/migration narrative, recognizing that stories cross space and time is significant (Bury 1982). Past experiences, present forces, and changing circumstances over time come together to form the im/migrant's life—a life that is lived through the mind and imagination of the im/migrant patient that is not bound by space or time, but is an accumulation of events across space and time. As such, the feelings and distress patients hold are a manifestation of experiences across time as well. Im/migration experiences become embodied, critical events that inform who an im/migrant has become and what they hope to achieve.

In response, within the context of im/migrant and refugee health, trauma-informed care is intimately connected to eliciting stories of forced migration. Butler and colleagues (2011, p. 185) note, “Understanding the complex interplay of trauma, dislocation, and adjustment in the migration process is an essential foundation for a trauma-informed perspective.” The matter at hand, then, is about how providers should understand and respond to trauma in im/migrant life.

There are two general clinical frames regarding im/migration trauma and im/migrant patients. The first sees im/migrants as traumatized victims without agency that require the treatment of professional biomedical providers (Turner 2019). An im/migrant's only hope lies in a provider's ability to help them heal and become productive denizens of the U.S. Im/migrants need to abide by the treatment plans put forth and succumb to the notion that American forms of healing are best. Subjectification to biomedicine—becoming a patient—is a virtue in this framework.

The second frame is that of resiliency, resolve, and resourcefulness, which draws on Healing-Centered Engagement and other clinical approaches that avoid pathologizing im/migrant histories. Here, people are more than their trauma. Care focuses on aspects of strength, purpose, and value rather than deficits as a result of traumatic experiences. Medical professionals will always be a necessity to ensure the health of im/migrants, but they and biomedicine are not the only quintessential elements of care. Related to this is building social and cultural capital as I noted before.

Rather than focusing on negative migratory events, Healing-Centered Engagement emphasizes fostering well-being relative to one's assets, knowledge, and supports. Providers can either have im/migrants concentrate on experiences associated with pain, or they can limit attention to trauma and have im/migrants focus on sources of strength and positivity in their lives— “what's going right with you” versus “what happened to you” (Ginwright 2019). We cannot just ponder the incidents of loss, suffering, and struggle in our lives; we have to consider our positive attributes and the people in our lives who give us meaning—what uplifts us, what nurtures us, and who supports us.

To substantiate these points, I would like to mention portions of the im/migrant narrative Clara shared with me.

Clara, an elderly im/migrant from the Greater Antilles, legally im/migrated to the U.S. over twenty-five years ago so that her daughter could receive advanced medical care for a congenital disorder. Without biomedical services and personnel, her daughter would have had a decreased quality of life and could have needlessly died at an early age. However, Clara feels differently when it comes to services for herself. A self-proclaimed “bad patient,” Clara has not taken to biomedicine in the same way as her daughter. “I’m supposed to take it [my pill] every day, but I don’t take it every day. I’m very bad with pills [...] I

hate to take pills.” Regardless of the assistance and benefits biomedicine has brought to her daughter, Clara struggles to adhere to the medical advice and treatment plans of her own providers. She lives in a middle ground between an acceptance and defiance to biomedicine (a common thread across patient interviews).

For Clara, this resistance comes from her notions of mental health care, seemingly a pseudoscience of quackery. Patients do not need mental health services, she thinks, but rather the innate strength to overcome their stress and anxiety. Clara says that she “blocks” her pains and controls her mind when bad thoughts arise. Further, in her eyes, her daughter has persisted because of a strong mental attitude, not just the help of biomedical care. “My daughter, she goes to a lot of therapies, and I, I really think how these people can help her. I think she feels better because probably she’s emotionally strong like her mom. Not because these people do something for her.” While biomedicine has helped keep her daughter alive and active, it is her daughter’s strength that has challenged disease over time. And her daughter’s resilience, Clara shared, is the source of her own perseverance. “I think she’s my medicine. That’s what I need [laughs]. She survives another day! It’s beautiful!” Biomedicine, regardless of how Clara interacts with it, has helped her daughter, and in response, provides her healing.

Rather than take pills or conduct psychotherapy, which do not align with her perceived “models of affliction” (Kirmayer 2004; see chapter five trust and communication), Clara’s im/migration journey and the source of managing her wellbeing is her daughter. “She is my medicine,” Clara says. Or, to frame this along the terminology of Ginwright (2019), her daughter is ‘what’s going right for her.’ The only way to know this, however, would be through listening to Clara’s story. Her narrative guides her care, and it informs providers about what she’s gone through, what keeps her well, and what motivates her to look towards the future.

Furthermore, Clara’s story also points to the significance of family, and so I argue that the family (and friends or other types of close social relationships) are a crucial aspect of structurally informed care. As opposed to thinking about social structures merely as the large, impersonal institutions that surround us, they also include the people

who help structure our lives—the people who form our social and cultural capital. To that end, macro-social structures inform the micro-social structure of individual im/migrant life, and therefore, structural competency and its levels of intervention must recognize the structure of individual life in relation.

Structural Competence

So, what does this all mean? Again coming back to Neff and colleagues (2020), it means that structural competence challenges the naturalization of violence and the ways structures cause undue harm. “Structural competency contends that many health-related factors previously attributed to culture or ethnicity also represent the downstream consequences of decisions about larger structural contexts, including health care and food delivery systems, zoning laws, local politics, urban and rural infrastructures, structural racisms, or even the very definitions of illness and health” (Metzl and Roberts 2014). Moreover, to be structurally competent is to take into account larger forces at play, removing the burden from patients and contextualizing the why of patient decision-making and illness propagation relative to embodied states of fear, distress, and unbelonging. It also combats arguments related to culture and ethnicity, bringing to light sociopolitical structures as drivers of illness and disparity rather than practices of The Other.

CHAPTER FIVE: TRUST AND COMMUNICATION

“I couldn't open up because I was scared of everyone. You know, we [im/migrants] always scared. We don't know. We just come in here thinking that, 'Okay, I'm going to be treated, but, who are you? How do I [as the patient] trust you? [...] Are they going to listen to me? Will they [doctors] take my words true?' So, you find them so worried that they really...[exclaims] They don't trust doctors! But again, after some time, good time with them, they [patients] will come explain, slowly by slowly. Me, it took 2 years.

– Margaret, female refugee from Uganda

Clinical research has repeatedly presented trust as a keystone of the provider-patient relationship (Holland and Stocks 2017; Pellegrini 2017). Without it, moving forward with evaluation and treatment for both parties becomes a dubious endeavor. The patient questions the abilities, motivation, and biases of the provider, and the provider thinks the patient will not consider heed recommendations. As the lifeworlds—and clinical realities—of patient and provider meet in the interpersonal space that is the clinical encounter, there may be barriers to trust (Hojat 2007; Kleinman, Eisenberg, and Good 1978). Furthermore, the development of trust in the provider-patient relationship is hardly straightforward and requires careful consideration of the patient's individuality and the ways in which the provider communicates.

In this chapter, I argue that im/migrant patients, because of their unique needs and backgrounds, require specific forms of clinical communication and trust-building efforts from their providers. To support my argument, I include three sections discussing communication and trust, each examining a unique dimension of provider-im/migrant

patient interaction. The first section is about the structural and institutional factors that influence trust-building between clinicians and their im/migrant patients. Here, I look at how im/migrants are fearful of state power before, during, and after migration which, I argue, produces a loss of personal agency that necessitates distinct forms of patient-provider interfacing.

The second section discusses the concept of provider-patient negotiation as introduced by Kleinman, Eisenberg, and Good (1978). In this section, I discuss what negotiation means in the clinical context of treating im/migrant patients. I contend that negotiation is a necessary part of clinical care, but that providers also acknowledge the base of their negotiation, biomedicine, exists at the top of a hierarchy of global healing systems. Negotiation, then, is about balancing efforts of conversation vs. coercion—a recognition that power imbalances between clinicians and patients, and biomedicine and other medical systems, may result in the patient making compelled decisions. In response, I argue the need for providers to consistently ask im/migrant patients questions, and when in disagreement, be mindful of the paternalistic tendency of biomedical practice, regard the patient's perspectives, and personalize a treatment approach that fits everyone's preferences.

In the third section, I explore notions of compassionate care between im/migrant patients and providers. Here, I introduce a concept that I term *the grace of small gestures*. These gestures refer to particular communicative considerations and sociomedical interventions that help build trust, such as friendliness, asking about the family, and delivering out-of-the-ordinary patient-centered solutions. While seemingly minor, I argue

that these gestures stand out to patients, intersecting at the root of stress and exhibiting to patients that their healthcare provider is invested in their life and listens to the small details they share.

My main argument in this chapter is that communication and trust between providers and im/migrant patients is a complex, multi-directional process. Neither patients nor providers are the sole origin of communication and establishing rapport. Both parties must work together, and in general, there is not a one-size-fits-all approach. Communication and trust, in this regard, are the outcomes of interpersonal adaptation. The provider may need to adapt their approach to individual patients, and patients may need to assist their provider with understanding how best to communicate with them in particular. An iterative process continues between the provider and patient over time. The aspects of communication I discuss are just three parts of what potentially fuels this feedback loop of trust-building. I do not claim that they are the most important. These areas, rather, are where my data pointed, and my goal hereafter is to frame them as a few meaningful matters of communicative and trust-building significance when treating im/migrant patients.

Linguistic Interpretation

As I mentioned in my background chapter, I do not discuss the presence or application of linguistic interpretation. Interpretation is a significant aspect of care delivery for im/migrants because they often have limited English proficiency (LEP) compared to other patient populations. This area of clinical research often takes center stage regarding care for im/migrant patients. In response, the arguments I present assume

such language services are available and that healthcare providers have the capability to use them. I do not make this decision to diminish the importance of linguistic interpretation, but to shift our gaze to other areas of communicative concern.

That said, there is one aspect of trust relative to linguistic interpretation I would like to note: who the interpreter is and where they live matters. In-person interpreters, while associated with better health outcomes, may live in the same community as the patient. This can result in the patient not sharing certain details for fear of breaches of privacy (New York State Psychiatric Institute Center of Excellence for Cultural Competence 2014).

The Social

In *The Art of Social Theory*, Richard Swedburg (2014) poses three questions: *What is the social?; What are the causes and effects of the social?; and How does the social change?* Through these questions, Swedburg seeks to examine how phenomena derived from human social interactions are formed, how they change, and why. For instance, using religious congregation as an example, *the social* might refer to how congregants constitute the act of congregating, how their religious congregating changes them, and how the sociality of their religious congregating itself changes over time. The point is that we, as humans, are both the founders and subjects of our socialities (Bourdieu 1977). Coming back to my example above, the congregants, then, live in tandem with their sociality—they form the social of congregating, but this also changes them. In other words, the social is about the act of sociality, but also about how *the socials* we build affect us.

For the purposes of this chapter, my outlook is that *the social* considers all parts of what makes up a patient's sociality, whether it concerns the family, school, work, religion, ethnicity, race, immigration status, or otherwise. What aspects of social being are a part of—or apart from—the im/migrant patient's current sociality? My argument, therefore, is that the loss of *the social* is just as important as the presence of *the social*. Indeed, the significance of sociality, whether an im/migrant or not, becomes most apparent when some parts of it are gone (House 2001; Schneller 1981). Therefore, the examination of human behaviors related to aspects of missing sociality, belonging, and human connection (e.g., isolation, separation, destruction, loneliness, quarantine) may be more important than readily observed social interaction and belonging. In terms of social capital, this refers to the loss or absence of a “network of connections”—the people who help us “characterize our social formation” (Bourdieu 1986).

Fear of the State: Structural and Institutional Factors

As Margaret's statement in the opening of this chapter notes, a common thread across almost all of my patient interviews is an initial fear associated with seeing the doctor. Sure, this fear could be boiled down to the uneasiness of potentially learning something is wrong with one's health or body, or even just the process of establishing a relationship with a new provider. But these experiences are common across all patients, im/migrant or not. The fear im/migrants feel, rather, relates to larger structures of state power, both domestic and abroad, that have produced a loss of personal agency in their lives. Embodied states not necessarily of simply unbelonging, uncertainty, and fear, but of loss—the evaporation of one's previous life abroad. There are two interrelated lenses I

discuss in terms of the reduction and rebuilding of im/migrant personal agency: 1) a loss of “the social” and 2) state power.

Forced Im/migrants and the Loss of the Social: Rebuilding Agency

The loss of the social is extremely relevant to forced migrants who often experience persecution, torture, and a lack of freedom (Onsando 2013). From this lens, the notion of choice becomes relevant. The conscious decisions we make to form and respond to our own sociality is what makes the power of *the social* special: My friends, My family, My church, My town, My sports team, My club, My community center, My world. We decide, by in large, with whom we interact and whom we include in our lives. However, when types of sociality are imposed or when larger powers prevent or destroy *the social*, suffering proliferates. Not only are the network and actors of one’s sociality gone, but the freedom to imagine and build a sociality is hindered. This is what it means to be a forced migrant: im/migration due to a “well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group” (UNHCR 1951). At the heart of forced migration, then, is a destruction—persecution—of *the social*. In almost all cases, such social annihilation comes from the hands of state actors.

While interpreting the thought of French philosopher Jean-Paul Sartre, Swedburg writes “There is more to freedom and the lack of freedom than the existential state of man” (p. 174). Regardless of the human capacity to imagine and build sociality, there are other acts of human freedom that nullify the freedom and imagination of others. In the case of forced migration, it is the imaginative freedom of agents in state power who

subject aspects of rule or conflict into the lives of the disempowered. As Hope, a refugee herself, told me, “Im/migrants come from countries where power is abused. And a lot of them [forced im/migrants] have trauma, and with people who demonstrate power, they cause an imbalance, and so [forced migrants] never feel free to express themselves clearly.” To put it simply, institutions and actors backed by state power persecute certain social groups and cultures, forcing human movement (Young 1982). As such, in the country of origin, no matter the sanctity of its grounds and the comfort it brought prior to persecutory upheaval, there is an association with times and spaces fraught with oppression and a lack of personal sovereignty created by the state.

Consequently, violence at the hands of the state creates an im/migrant fear of governmental institutions and personnel, and the clinic is associated with government—a place that im/migrants should avoid. Embodied states not solely of unbelonging, loss, and marginality, but of clinical irresolution—a hesitance to associate with hospitals, medical clinics, and healthcare professionals when ill. A provider participant I spoke with framed this fear and loss of agency like this,

For many of them [im/migrants], they will have experienced it [a loss of agency] along a continuum. So, if they're refugees, they will have experienced a loss of power and agency just by being displaced from their home country [...] if they have experienced torture, then it's even another deeper loss of power and agency. [...] In all these cases, it tends to be at the hands of government actors. So, in some cases, people are tortured by government agents, and in other cases, people are tortured by non-government agents because the government is not strong enough to protect them. The message they've gotten very clearly is that the government sometimes can't be trusted or officialdom can't be trusted and is a dangerous thing. And for most of these folks, healthcare is a government actor; healthcare is a government service, so they map that understanding on when they come to the U.S. So, they're bringing the baggage of their experience with government actors right into the exam room, but also everything leading up to it. Getting healthcare coverage, signing up for that, showing documents, having to

go to various offices, having to call various bureaus or organizations. So, they bring that right into the exam room, where they feel...most patients will assume that you are somehow related to the government. So, all those things, even for people who were, who had a great deal of agency before, they will have either lost it, or have it shaken.

Im/migrants bear experiences of state betrayal as they im/migrate—they become part of their new sociality. As the provider above brings to light, these notions become a type of “baggage” that im/migrants may lug around for the remainder of their lives. Persecution and forced movement from one’s home is not simply forgotten. These memories are etched into the mind—embodied—and forever affect perceptions of government actors and institutions. This is no different in healthcare facilities, often highly bureaucratic spaces. Providing an ID, filling out forms and documents, applying for services, and the other administrative tasks patients undergo cause much anxiety and uncertainty for im/migrants. Moreover, Joseph (2018) points out, “The standard verification methods [at medical clinics/hospitals] are harmless for most patients but create additional concerns for im/migrant patients.” Im/migrants may worry that the state, through healthcare facilities, is surveilling them, a concept aligned with Michel Foucault’s writings on state panopticism in *Discipline and Punish: The Birth of the Prison*.

Expanding on Jeremy Bentham’s panopticon prison in which every cell is in view of the watchtower, Foucault (1977) theorized that the state, through the regulation of schools, workplaces, mental asylums, and other social spaces, is always watching and seeking to discipline. As Margaret told me, “Im/migrants, they think that you [healthcare personnel] might be a spy. You want to know who I am and I might be in trouble and you

take me back [deported].”

Based on Margaret’s statement above, im/migrants frequently draw a connection between the risk of deportation and seeking healthcare services via a fear of government “spying.” For any im/migrant, this is likely their worst migration related fear—embodied consternation that any single movement or decision will result in deportation. Regardless of their im/migration journey, no im/migrant envisions or desires to be forcibly removed—a secondary (or tertiary, etc.) forced migration—from the United States. And while healthcare facilities and personnel are not the only institutions and professionals im/migrants perceive as a threat to their position within U.S. borders, there is a need for providers to be equipped to mitigate patient concerns and swiftly build trust when im/migrants do seek care. The provider above continued to say,

When they [im/migrant patients] walk in, it's really important from the start to explain to them that, you know, they're there by choice and we can't tell them what to do in any situation. We can only strongly recommend, and again, to emphasize that decisions are theirs. We're there to support them and provide them information, but decisions are theirs. In the best circumstances, we support them as they regain some of their agency and power. But, it's important to continue to emphasize in encounters with healthcare that they are in charge and they are the ones who make decisions. At the best, I think, on a daily basis, all patients feel a loss of agency in healthcare. But it's more acute for these folks, and it's even more important to remind them that we're giving it back to them.

A significant objective for providers giving im/migrant patient’s back their agency—a semblance of control over a part of their lives: the ability to decide what they want to share and have done to them. While this does not mean that patients have the outright say regarding clinical decision-making due to safety and liability concerns, it does mean that patients have the opportunity to confirm or deny any medical related intervention. Patients have the command, and providers are simply there to communicate

ways they could help. In large part, this return of agency emerges from providers asking patients their permission, which in many ways relates to trauma-informed care approaches.

Treat everyone the same way and [emphasize] assume they've had some trauma experience. So, from not closing the exam room door to explaining the physical exam to them as you go and beforehand in a very detailed way. Whether it's, you know, just a cardiac exam or looking in their eyes, or a pelvic exam, be very explicit about explaining things and getting permission to go ahead with any kind of physical maneuver. So, it's just about being very conscious about explaining what you're doing, previewing what you're doing, and asking patients for their consent for things as you go along. 'I'm going to look in your ear now with this otoscope, is that okay?' Maybe they had ear trauma as part of their torture, and they may say, 'No, I don't really want that,' and you have to give them the power to be able to say, 'No. I'd rather not do that,' even though you just think of this as standard care.

The key, therefore, is the assumption of trauma, a clinical approach about which a few providers disagreed. The provider above notes that, because of the high prevalence of traumatic experiences across im/migrant patients, clinical personnel need to assume traumatic experience and deliver care through constant explanation and asking for consent. Conversely, another provider I spoke with holds a contrary approach. “I do not assume anything about my patients.” This lack of assumption makes sense in terms of patient-centered care and cultural humility. Every patient is unique in terms of life experience and how they engage with the sociocultural worlds around us (National Clinical Guideline Centre (UK) 2012). As Zoe, who came to the U.S. as an asylum seeker, heedfully put it, “What has worked with one patient might not work with another patient regardless if they come from the same country. Cause even, even within the same country there are different cultures.” A lack of assumption is to let care genuinely lend itself to each individual patient as they deem and require (Sugarman 2018)—enabling

care to embrace and respond to the embodied states and needs of the patient.

Because of the diverse collection of human experiences and ways of being that intersect with structural forces, there is a need for considering how individual people, from distinctive cultural and ethnic backgrounds with diverse beliefs, values, customs, experiences, and practices perceive the world and give definition to objects, people, and institutions—aspects of the patient’s *being*. Yes, taking into account the effects of structural violence and integrating other forms of social and psychological theory into customary medical education and clinical practice is invaluable (this is the heart of im/migration as a structural determinant of health).

However, understanding the influence and presence of a patient’s culture is important for providers; understandings and assumptions of not necessarily how a patient’s culture or community exists, operates, or functions, but considering that the patient has a culture. A culture consists not only of the shared values, beliefs, and customs of their community—and the structural forces around them—but also of the patient’s experiences and interpretations as an individual. I term such methodology as a *biosociocultural* approach. This adds to the former biosocial and biopsychosocial approaches to health. A focused dimension of culture—through sociocultural analyses that integrate and operationalize knowledge, practice, and skill that considers the patient not just as an individual with ailment and/or experiences of structurally derived violence, but as somebody who also has beliefs and values that influence them as a lived being with distinctive perspectives, ideations, accomplishments, losses, desires, fears, joys, or otherwise, no matter communal belonging. It is to acknowledge the patient comes from a

culture, but that they experience such in their own way relative to their own life—their own being.

Contrastingly, the assumption and presence of trauma could be different, for when a provider does not assume trauma there may be instances and episodes of patient retraumatization, no matter how seemingly small the trigger (Center for Substance Abuse Treatment (US) 2014). This is not to say that patients' experiences of trauma are not unique or all their own. On the contrary, because of the particularities of how victims of trauma impute meaning to these experiences, providers not making assumptions regarding the physiological and emotional effects of trauma on the patient is essential. To that end, assuming trauma can lead to harm-reduction, where there is the balanced acknowledgment of patient-centered care with a constant wariness of possible traumatic experience. This permits care that is individualized, while allowing room for a protective factor for retraumatization. Moreover, when providers account for possible trauma and patients regain agency through a consistent gathering of consent or refusal of care, there is a greater possibility of trust-building. Regular communication before “physical maneuvering” and a “conscious”—embodied—awareness of how simple acts connect to traumatic experience builds trust between patient and provider. These acts leave an impression on patients that the provider is mindful about their experiences and is willing to let them have control over their bodies which previously may have been significantly violated.

Engage the Patient through Question-Asking

Returning to the provider's statement above regarding limiting all assumptions,

most patients agreed with them. Often, and not unlike most patients, the im/migrants I spoke with told me how they want their providers to ask them questions about how to best treat them as an individual with particular beliefs, upbringings, stressors, and needs, or as Zoe continued to say, as a whole. “I think the patient should be treated [pause] as a whole. As a whole entity. As a whole unit. As a whole person.” But, what does treating the patient as a whole entity mean?

One provider told me, using the same notion of a “whole” as Zoe, that it means acknowledging the many different aspects of life that coalesce to form our individual being. Or, in other words, taking account of the many pieces of the patient that make them who they are. “You don’t take care of a part, you take care of a whole,” they said. “So, I am looking at you, tell me what is going on, that is what I am talking about. Eliciting everything that is possible, so you know that patient.” In order for providers to adequately deliver care, understanding the patient they are treating is crucial. What matters to them, what they need, what they prefer, and as another provider told me, “what the patient is expecting to get from you [as the provider].” When the provider asks these types of questions, patients become engaged and share their concerns and anticipations for care (Filler, Jameel, and Gagliardi 2020). It shows that the provider, as Kelly et al. (2019, p. 968) writes, does not “treat the body as a brute fact of nature,” but as “a rich resource for human understanding.” In other words, engaging the patient through questions about their life brings to focus bodily experience—to move inquiry from ‘about the patient’s body’ to ‘how the patient’s body exists.’

Negotiation Across Explanatory Models

Furthermore, as Margaret shared with me, question asking is the only way for providers to determine the ‘why’—root—of a patient’s illness and what could be done in response,

Margaret: They [im/migrant patients] need a lot of listening. Yes. And taking time to listen and to, to ask more questions from them. Not only that, 'Are you sick?' What they should do, they should at least know what's going on...[emphasizes] Why! Why! Let's say an example. I have high blood pressure. 'Why do you have high blood pressure? What happened?' But if you start treating my high blood pressure, if you don't know the cause, then it won't help.

To a certain degree, the passage from Margaret above references two important anthropologically founded aspects of cross-cultural communication in clinical encounters, meaning-centered analysis and explanatory models. First introduced by Kleinman, Eisenberg, and Good (1978) and later elaborated by Kleinman alone (1981), meaning-centered analysis and explanatory modeling concern the “cultural construction of clinical reality”; exploring how the patient experiences their illness, how they perceive its source, reasoning and explanation, and how they characterize it within their individual lifeworld. Importantly, illness and its meanings are the product of what Kleinman, Eisenberg, and Good (1978) call *cultural patternings of sickness and care*.

Illness is culturally shaped in the sense that how we perceive, experience, and cope with disease is based on explanation of sickness, explanations specific to the social positions we occupy and systems of meaning we employ [...] How we communicate about our health problems, the manner in which we present our symptoms, when and to whom we go for care, how long we remain in care, and how we evaluate that care are all affected by cultural beliefs (p. 252).

Neither disease nor illness are empirical phenomena; “they are concepts of explanatory models mirroring multilevel relations between separate aspects of a complex,

fluid, and total phenomenon: sickness” (Kleinman, Eisenberg, and Good 1978). This is all roughly equivalent to saying that sickness is not defined in one way, and to that end, that biomedicine’s taxonomy of disease and treatment is not intrinsically correct. As biomedical providers hone-in on curing diseases of the body, the explanatory models of patients—which correlate with the patient’s socially and culturally embodied perceptions of health, illness, and healing—are often ignored.

When treating im/migrants, those who come from all parts of the globe carrying a variety of traditions that inform perceptions and beliefs about illness, providers might find it helpful to ask these patients about what they think is going on and what they think should be done. As Devin, an im/migrant nurse informed me, im/migrants will not take their medication if they do not think they will work. “The first thing they [the provider] should do, they [should ask the patient if they] believe in medications? Cause some people, the doctor give them medication, they don't take it though [chuckles]. They just go home. They be like, ‘I'm not taking all that.’ They don't take it [...] The doctor's got to be like, ‘Do you believe in medication?’” Medication adherence is directly connected to explanatory modeling. If a patient finds that a medication, or any intervention, is not connected to their perceptions and experiences of illness, they will not adhere nor consider it helpful. As Kirmayer (2004) puts it, “Modalities of healing follow from the associated model of affliction.” The models of affliction healthcare providers use and that im/migrant patients use often do not align, so it is significant that providers discuss with these patients what measures should be taken.

This act of discussion and questioning across explanatory models is what

Kleinman, Eisenberg, and Good (1978) call *negotiation across clinical realities*, possibly “the single most important step in engaging the patient’s trust” (ibid p. 257). Here, the provider “actively negotiates with the patient, as a *therapeutic ally*, about treatment and expected outcomes.” Significantly, however, Kleinman et al. (1978) do not provide a stepwise process for negotiating with patients, and this, as they note, is due to the infinite ways differences may exist between patients and providers in the clinical encounter. For example, Shauna, whom I mentioned in my introductory chapter, accepts the use of radiographic imaging and orthopedic surgery for her spinal injury, but believes that using the herb Strong Back (*Desmodium Incanum*) is necessary to treat pain. Caroline, a Somali refugee, noted that in her community, during the COVID-19 pandemic in particular, there has been a connection between “faith and disease.” Rather than consider SARS-CoV-2 as a dangerous virus that can be prevented and treated, they see it as a diagnosis of destiny that God will cure if one is so destined. The truth of these matters are not for the provider to decide, but they are for them to discuss and take into account. This is where Kleinman et al. (1978, p. 256) recommend a list of eight questions that can help discern a patient’s explanatory modeling. While not a step-by-step process with methods for effective negotiation, these questions can help contextualize what and how a patient thinks about their illness and care: 1) *What do you think caused your problem?*; 2) *Why do you think it started when it did?*; 3) *What do you think your sickness does to you?*; 4) *How severe is your sickness?*; 5) *What kind of treatment do you think you should receive?*; 6) *What are the most important results you hope to receive from this treatment?*; 7) *What are your chief problems your sickness has caused you?*; and 8) *What do you fear most about your*

sickness?”

Moreover, a few patients gave recommendations of their own for providers when there is disagreement across clinical realities. Regarding medication adherence, in particular, patients noted that providers should diligently explain the benefits of a medicine and clearly state how it will specifically help them in numerous ways. For example, Clara told me,

Clara: He [my provider] told me that the pill is not only for your high blood pressure, but they [the pills] have some benefits that you need right now. That does make me feel okay. I need this pill because something is wrong in my body. And sometimes people [im/migrant patients] think they can, they can have the control. The patient thinks I can have the control of my situation or my health when it's not. But, in our minds, the patient's mind, the doctor just wants to give me a pill. But, it takes a little bit more time for the doctor to explain it and why. It's not only one benefit. This one can help you with this, you know. That's very important.

As Clara alludes to, it is important that providers take additional time to explain how a pill/medication works inside the body, or what it is intended to do to the body. To that end, she adds that it is best if providers articulate the particular aid pharmaceuticals will provide. But Clara also mentioned something else that needs additional investigation. She says that many im/migrant think providers “just want to give pills,” a perspective attuned to the notion that providers simply want to push pharmaceuticals. There is some truth to this matter as Fickweiler et al. (2017) describe. Pharmaceutical companies work very hard getting providers to prescribe their products, and there is no reason to assume that im/migrant patients are an outlier on the receiving end. Keeping in mind Clara’s statement above, im/migrants may perceive a prescription in terms of the provider avoiding actually dealing with them. They may feel ignored and dismissed, developing

an embodied distrust of the provider. There is a need, then, for providers to be cognizant of how and why they are prescribing for im/migrant patients, a population that already has trust issues with the healthcare system. However, it should be noted that many of the pharmaceuticals im/migrants receive are affordable generics, such as hypertension medications, non-insulin therapies (e.g. metformin or sulfonylureas), and SSRIs (selective serotonin reuptake inhibitors).

Additionally, a number of provider participants had recommendations of their own when there is discrepancy between the explanatory modeling of patient and provider. For these providers, the aspect of utmost importance is the patient's safety. If a patient holds views, practices, and/or beliefs that the provider does not agree with but do not hurt the patient, leave the matters be (i.e. work around the discrepancy). As Stavert-Dobson (2016, p. 3) writes, "In the delivery of healthcare it may be better to do nothing than to intervene and risk causing harm."

For example, a pediatrician told me that many of their patients (and the patient's parents) practice coining and cupping, traditional healing remedies from East-Asian cultures. Coining, also known as *Cao gio* (Vietnamese translation: "catch the wind") or *Gua sha* (Chinese translation: "scrape" and "rash"), consists of vigorously rubbing the skin with a coin, spoon, or metal cap to rid the body of "bad wind," an asymmetry in one's ying-yang (Vitale and Prashad 2017). Wet and dry cupping, on the other hand, includes using suction cups applied to the skin for the purpose of creating hematomas that rid the body of harmful substances and toxins. The provider I spoke with does not personally believe in these practices nor overtly encourage them, but they also said they

do not frown on them either. “If the patient’s doing it, then I say that is fine if you [the patient] think it is helpful and you like doing it. As long as it is not something that I know it has the potential for harm.”

However, if cultural practices are a danger to the patient or that of others, the provider intervention is necessary. For example, this provider also noted an instance in which they openly communicate the dangers of an alternative medical practice. For colic, frequent and intense crying in an otherwise healthy infant, the provider found that many of their patient’s parents give their babies a holistic, herbal remedy containing the plant Belladonna (*Atropa belladonna*). This plant, as the provider explained, is the origin of the chemical compound digoxin, which treats arrhythmia and heart failure.

So, there is this big company called Highland, big business, that markets herbal remedies, holistic health stuff and they had this colic stuff for young infants that contained Belladonna. Belladonna is the plant that is the origin of digoxin, digitalis for, you know, cardiac treatment, and I would see parents asking me or giving this stuff, telling me about it or asking me if it was okay, and I would just say, you know, look at the ingredients of this. You are basically giving your kid the plant-based version of digoxin which is what we treat heart failure with. Why would you ever want to do that?! And in fact there were lawsuits because it was having cardiac effects on infants and there were some deaths and they ended up being ordered to withdraw the product from the market. So, that is the type of situation when I say something.

In short, if a patient employs healing remedies that are a danger to their wellbeing, it is the provider’s obligation to protect their health and safety. This, however, is a balance between knowing what is and is not actually dangerous. While coining and cupping may appear hazardous, they come from centuries of healing practice with an evidence-base. In many instances, this is also true with respect to phytopharmaceuticals, which humans have used as medicine for millennia (Petrovska 2012). The key, then, for

providers, is understanding the history of an intervention, the context in which it is used, and to what extent. Digoxin, the chemical compound used for heart failure, is not inherently dangerous to human health; it is dangerous when given to infants with a healthy heart. Such critical analysis of any healing modality a patient uses is necessary.

Another provider recommended a brief, overarching suggestion to keep in mind when working across explanatory models. “Really pay attention to where patients express resistance.” These are moments ripe for conversation, exploration, and shared decision-making. For when a patient shows hesitance about an intervention or does not adhere to a treatment, there is usually an underlying *why*. It is of the foremost importance that providers engage patients in these circumstances and respectfully inquire about their rationale and preferences to determine culturally aligned care moving forward. In terms of knowledge capital, these are tremendous opportunities for providers and patients to exchange ideas and inform each other about new perspectives. Here, providers can truly gain insight about the lived experience of the patient, bridging the concepts of cultural and social capital to deliver patient-centered care (Dubbin, Chang, and Shim 2013).

Converse, Don't Coerce

In terms of clinical negotiation, though, there is the matter of power. As I noted earlier, the medical taxonomy and practices of biomedicine are not empirically correct, but one manner of thinking about and treating sickness. Biomedicine, to that extent, exists at the top of a hierarchy of global ethnomedical healing systems and has been associated with paternalism (Gallagher 1998). As a result, biomedical providers have the upper hand when negotiating with patients because many see their knowledge and

profession as the product of an objective, pure truth—biomedical science. Because biomedicine is often considered the ‘right way of healing,’ negotiation, as a provider participant put it, implies the goal of “getting them [the patient] to your way of thinking.” As such, there is a difference between conversing and coercing—working together with the patient to make a shared-decision versus pressuring the patient into making a decision of appeasement they may not prefer.

Furthermore, conversing gives providers the opportunity to learn about new ways of healing from patients. The same provider above continued to say, “I’ve found over and over that I’m very humbled by what patients have taught me about what they know about health.” When a provider lets go of the paternalistic process of pushing patients to think biomedically, it opens up the conversation for many possibilities of care. Providers and patients can learn from each other and come to an arrangement that meets everyone’s preferences. This, as Margaret shared, also builds the patient-provider relationship through mutual humility. “[We need] to be humble to each other. You [the provider] are humble to me, I [the patient] am humble to you. Meaning things will work out between me and you.” Humility is the fuel of building rapport. As providers and patients work together to make joint decisions, there is an amalgamation of knowledge that benefits all without minimizing the views of the patient or aggrandizing and exclusively privileging the methods of biomedicine.

This avenue of humble care delivery means practicing what is known as *cultural humility*, which Hook et al. (2013) define as “having an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward

an individual's [the patient's] cultural background and experiences." The point is for providers to reflect on their own ways of being and why they think about medicine and health in a certain way. As a provider I spoke with explained,

Providers need to know their own sort of 'cultural blinders.' Ways in which they have been enculturated; not only in their own sort of family, ethnic regional, cultural background, but also in medicine. The ways in which healthcare providers have been enculturated to think of bodies and body systems and people and health in a particular way, which is a cultural way; one cultural way and not the only cultural way.

Beyond biomedicine, there are many ways of knowing and explaining illness symptoms and sickness. The objective for providers, therefore, is not only to acknowledge that biomedicine informs the ways they view ailment and treatment, right from wrong, risky vs. safe, but, also, to ask the patient questions. The patient is unlikely to share what matters to them if the provider does not ask.

A lot of the folks I have talked with have been refugees, and [they] will politely listen to what a provider tells them to do or [take the] prescription or [agree to a] particular treatment and smile and nod and then throw the pills away or you know disregard what the provider said or just tell them what they want to hear and go on about their business. I think it takes a while to really build trust and with patients and to be curious about the ways they're not only receiving information but getting other information about their health. To make it okay to share, 'Hey, I do this. I, you know, use herbs, I use prayer, I use, you know, these particular rituals or substances that you may have never heard of. But you are only asking me certain things, so I am going to only answer certain things.'

Through efforts of cultural humility, providers can ask relevant questions beyond the scope of biomedical practice, giving patients the opportunity to share the unique ways they go about healing. Clinical efforts that do not include other realms of ethnomedicine, such as prayer, herbs, and ritual, eschew important aspects of the patient's clinical reality, setting up care for failure. Therefore, I contend that negotiation is a non-coercive process

where providers engage the patient in critical cross-cultural inquiry for the purpose of shared decision-making. As I will show in the ensuing section, this process, due to the timely efforts of trust-building, requires patience and acts of genuine caring that mitigate stressors in daily life.

The Grace of Small Gestures

Margaret, an elderly refugee woman from Uganda whom I have mentioned throughout my thesis thus far, was one of the few participants I was able to meet in person. Whether it is because of this reason, the depth of the information she provided, or a combination of both, this interview is ingrained in my memory.

I met Margaret in a building on BMC's campus, arriving early because I had never been myself. Entering, there is the aroma of toasted bagels and coffee coming from a little cafe. A small corridor connects this cafe to the lobby, and chairs line its walls. Numerous patients sit, perhaps waiting to further engage with the U.S. health system or go home after an encounter. Security personnel staff a large, circular desk where they surveil and monitor visitors, a possible instance of Foucault's theories about panopticism. Seemingly uninterested in me, they allow me to pass; I enter the elevator and go up to the interview room without having to show any sort of identification.

I enter the room and take a seat in the chair facing away from the door, thinking that participants may feel more comfortable if they can see the room's entrance at all times. I consider the power dynamic of seating positions, conjuring up images of offices and meetings from personal experience, TV, and movies which exhibit powerful individuals as the ones seated behind the desk, always in view of the doorway. I begin

preparing for the interview, going over the protocol's questions and the interview techniques I learned in my research methods classes: ask open ended questions; ensure the participant clearly understands the questions; remember your interview probes.

I glance at the time, noticing Margaret is running behind. I send her a text to check-in. We had confirmed that she knew where to go and would call me when she arrived. Perhaps the security personnel asked for her identification and she was having trouble getting into the building, I think to myself. Or, maybe she just got lost. There is a reason why we have patient navigators in clinics and hospitals.

She soon responds to my text, informing me she had arrived some time ago. I am caught by surprise, and I feel rather embarrassed to have kept her waiting. I rush out to find her, and upon stumbling out of the clinic in my haste, I see an elderly African woman. She is dressed in a mix of traditional African wear and clothing one would normally see in Boston's late winter. I make an effort to regain some semblance of composure—like that of a *real* researcher—and ask, “Would you happen to be Margaret?” “I am,” she says. “Are you Jason?” I confirm, and we make our way into the clinic as we continue to exchange some pleasantries. “It's nice to meet you, Margaret. Have you ever conducted an interview like this?” “Yes, I have. A few times.” That she is somewhat familiar with the interview process gives me a calming feeling. I wonder if she could sense my nerves? We enter the interview room and take our seats at the table. Throughout our conversation she invokes a theme of compassionate care.

All interviews, either patient or provider, began with an introductory question inquiring what they think is most important for delivering excellent, high-quality care to

im/migrant and refugee patients. As a refugee herself, Margaret noted that the most significant, overarching aspect of treating im/migrants is empathy—acts of kindness and compassion that recognize the struggles and pain these patients have gone through. She repeats that im/migrants, under most circumstances, do not want to leave their home. She adds that when such a decision has to be made, once leaving, an entire world is left behind. “That journey from the house [home country] [laughs], it is a decision they [im/migrants] make which they don't want to do, but they have to do it. Sometimes it's war. Sometimes it is politics. If I don't, if I don't move to this place, I'm going to be hurt here. So, you just go. Know you are leaving everything of yours.”

The emptiness that leaving one's home brings forth is a critical component of healing im/migrants, and it is paramount that providers engage patients about how and why they were forced across international borders, what/who they have lost, what/who they miss, and what they one-day hope to (re)gain.

This notion of nothingness through loss, for Margaret, is the cornerstone of why compassionate care is so important. Already taking into account the loss of agency many im/migrants feel, the added stress, adversity, and scars inflicted during forced migration necessitates a sensitive, kind-hearted form of clinical care. Im/migrants yearn for genuine human connection with someone who holds a position of power, and the patients I spoke with termed this in a couple ways. Margaret stated that providers should “bring patients near to you,” adding that effective communication and care comes from understanding that im/migrants are often “heartbroken,” left to fend in an unsought liminal space relative to home and the struggle of maintaining life in the U.S. (Ghorashi, de Boer, and

ten Holder 2018). “There are very many things that can bring a healing to someone,” Margaret says. “Just even by a hug, listening to me [...] In this world, all we [im/migrant patients] need is encouragement, someone to talk to.”

The simple act of taking the time to speak with and listen to the im/migrant patient can be healing in and of itself. In combination with acts of affection—such as hugs—that embody efforts of considerate, human connection, there is even greater potential for im/migrant healing. As Dr. Lucy Hornstein, a physician in Pennsylvania, stated in their contribution to an advisory.com article discussing whether or not healthcare providers should hug their patients, “How much more visceral and subliminally can you express that you care about someone? You can say, ‘I care about you,’ and touch them on the arm or shake their hand, but that's not the same as putting your arms around someone. It's the most primal way of expressing care” (Advisory Board 2018). In agreement, Kelly and colleagues (2020) advance that touch is an effective way for providers to “embody empathy” towards their patients. Notwithstanding, boundaries, consent, and context are paramount.

Devin, from his own experiences and observations as an im/migrant nurse in a clinic that exclusively treats im/migrant patients, noted that providers should simply go to the “same level of the patient.” This effort of the provider letting go of their authoritative stature helps drive communication, rapport, and trust. Providers can build connections with their patients by seeking to bond with them as an individual—truly ‘seeing’ the patient. This a delicate notion to unpack, and it is entwined with metaphysical longings to heal the patient and remove the sorrows that pound away at their physicality,

consciousness, and self-worth. “I look at you and see all the ways a soul can bruise, and I wish I could sink my hands into your flesh and light lanterns along your spine so you know there’s nothing but light when I see you,” writes Shinji Moon (2013), poet and author of *The Anatomy of Being*. Meeting the patient “at their level” means embodying the genuine desire to heal and empower the patient. Such considerable efforts, though, only come via the patient, the one who guides the context and goals of care delivery.

Providers Cannot Be Cold

Overall, one of the key aspects for providers to consider is never giving patients the cold-shoulder (expressions of dismissal or the act of disregarding someone). Im/migrants, like any other patient, want their thoughts and concerns heard, and further, as I have noted throughout this chapter, yearn to connect with their provider. This cannot occur if the provider disregards and/or ignores the patient (Finset 2012). Shauna told me a story that is particularly symbolic of what she believes a provider SHOULD NOT do.

Shauna: I went to a doctor [...] he's an orthopedic, and [...] I was so happy when I went there. I'm sitting there waiting on him and he came in, 'Hi.' Like, just 'Hi?' [I] said, "Hello." And he said, 'How are you?' [I] said, 'I'm fine. How are you?' He didn't say nothing back [giggling to self] [...] He just switch from there, and he said, 'What's your pain level today?' Like, with that strong voice. Like, that...I'm not illegal, but that makes me feel like you're illegal. So build a relationship with your patient. That's all it takes.

In this scenario, the provider ignores Shauna. He disregards her attempt at exchanging pleasantries, and subsequently, there is immediate damage to the potential for trust building. Originally happy and budding with excitement to meet the surgeon who might fix her spine, Shauna became dismayed when it appeared that the provider only cared about her body—he did not seem interested in her as a person. Any patient might

feel upset under such an occurrence. But Shauna, and other im/migrants alike, may perceive such action as a personal affront relative to im/migrant status. What she thought would be a helpful medical encounter, turned out to be a stressful experience akin to the discrimination unauthorized im/migrants often feel (Szaflarski and Bauldry 2019). While Shauna herself was not unauthorized (at this point of her life), she felt a lack of respect through her provider's disregard for meaningful conversation and interaction with her.

To that end, friendly chatter before delving into medical care can help build trust and communication with im/migrant patients. As Filler and colleagues (2020) found in a scoping review of the barriers and facilitators of communicating with refugees, “Establishing rapport by greeting and welcoming the patient, taking time to chat informally, and adopting a friendly, caring and respectful manner” (p. 6) have positive effects on the patient-provider relationship and communicative outcomes. In agreement, patients, such as Elaine, mentioned that conversing about non-medical topics such as the patient's family brings the patient and provider closer together. Im/migrant patients perceive such inquiry as the provider's authentic interest in the other important affairs of their life.

Elaine: My doctor always asks, first thing she will ask me, she says, 'Hello' and she's asking me about my family. She knows a lot about my family, like, we talk about kids marrying. We talk about family and all that. And she gives me some advice and, yeah, it's been a [struggles to find words] I, I really don't wanna change my doctor. She's been my doctor since I came 23 years, 24 years...since 1997 she's been my doctor [...] She never forgets to ask me those questions. Just to make sure things are okay with me.

The things that make us feel well, or that cause us to feel sick, are connected to social life—to the people and events that we hold dear (Umberson and Montez 2010).

Subsequently, engaging patients about the happenings in their lives and determining what matters most to them is important.

Moreover, Hope mentioned that providers need to check their attitude before entering the exam room. Regardless of how stressful, tiresome, or difficult the day has been, providers cannot emotionally or cognitively bring other matters into encounters with patients. Patients can feel the bad energy these mental states emit, and this alters their clinical experience and perceptions of the provider. “Some healthcare providers, sometimes they could be having, like, a bad day or they are stressed. I will say that maybe they shouldn't, like, show that to their patient,” Hope said. “Like, they [the providers] walk in the office and then their attitude is not really good [...] So, I will say about the communication tone. The tone doctors use when talking to their patients shouldn't be, like, showing any sign of dislike.” As Hope notes, patients can sense tone, both in language and the aura it exudes (Haskard et al. 2008). When the provider's tone is negative, whatever the reason, im/migrant patients may perceive it as dislike, disinterest, or disregard.

Social Interventions for Social Stressors Build Trust

Margaret also mentioned other actions of care that tangibly help and heal im/migrant patients. These are interventions that have concrete impacts on the daily stressors im/migrants face, subsequently helping build rapport as everyday needs are combated. Under/unemployment, food insecurity, lack of home essentials and clothing, and much more affect the daily, lived reality im/migrants face (National Academies of Sciences, Engineering, and Medicine 2018). “Here. Now you are in the U.S. Where will I

start? No plate. No cup. No bed. No bed sheet. You know, all that mixes them [im/migrants] up and trauma comes. They [pause] they think all those things,” says Margaret. Everyday stress, everyday struggle, and everyday adversity; these are reminders that one has come close to losing everything. In response, though, Margaret says social interventions that combat the root of stress help im/migrants heal the most.

***Margaret:** They [providers] could do is make others [im/migrants patients] to be ready for a job, you see. Then they teach them the way they are going to do it, how you...even dresses [and suits], some of them were given. ‘Okay, you are going to dress like this.’ And then they go...and they got jobs! [...] And then, you know, even, they come from countries, very hot places. They come here [Boston, MA], it is very cold. Then, they think, ‘Where am I even going to get this heavy clothing?’ It makes them, again, think a lot. But, you know, at least, they, Boston Medical Center for Refugees have put something...They [im/migrant patients] go there, they get a coat. That is a part of healing these people. They are loved. ‘I am given shoes. I am given a coat. Now, I’m warm.’ You see. So, it heals them in many many ways. Yeah. By giving them even the food. Say, ‘Okay, now I’m loved. I am given food. [pause] Somebody is there for me.’*

Simple, sociomedical acts such providing a coat, pair of shoes, or job-interview training address and mitigate the worries and stressors im/migrants deal with as they seek to rebuild life in the U.S. As Margaret alludes to, many im/migrants, without fault of their own, are ill-prepared to do this without help. Im/migrants, in order to flourish, need access to services and interventions that help improve life trajectory. “To succeed, they [im/migrants] need a good start,” said Devin. Job-training, as Scheibelhofer (2019) notes, directly addresses the systems of social inequality and rebuilds im/migrant personal agency. Of course, this is also relative to the type of job one has, and Orrenius and Zavodny (2009) note that im/migrants are often willing to take risky, dangerous jobs. But, the overall intent of helping im/migrants get jobs epitomize genuine acts of care and support—measures that warm the body, heart, and provide glimpses of a better

tomorrow. This, as Mattingly (1994) describes, helps patients plot a course into the future, constructing new narrative. There is a grace in the provision of such small gestures. They provide solutions to a direct need and exemplify true benevolence, especially for im/migrant patients who may come to the U.S. with very little.

Again, I would like to return to Shauna. Shauna came to the U.S. from the Caribbean as an unauthorized im/migrant seeking a better life. Following her discharge from the hospital, Shauna told me stories about her experiences with the two primary care physicians she has seen since. In this chapter, I share Shauna's tales with her first provider, and in the conclusion, for comparison, I return to the second (Note: Shauna did not inform me why she transferred physicians, whether this was her decision, or whether her original physician left BMC).

Still using her friend's name, Shauna began seeing her first physician for many years. Over time, she says, "We gained the type of relationship where my heart just starting to trust her." "But how did the doctor gain this trust," I asked. Shauna shared that her doctor offered tangible solutions to address her needs. When financial insecurities, lack of housing, and stress brought her to a breaking point, Shauna described what could be considered abnormal biomedical treatments.

Shauna: The reason why I starting to trust her, she, I told her that I didn't have money. I didn't...that I'm not working and I have no family here, which I really don't. And, she brought me a bag of clothes...[speaking with amazement] This is a doctor? She brought me a bag of clothes, she gave me a Macy's card with \$50 on there, and she gave me a Dunkin Donut card, which I'm very addicted to Dunkin Donuts. [subject and interviewer laugh] So, I got those from her, and tears came to my eyes. And I was like, 'Should I tell her [I'm homeless]?' I'm starting to get, gain that trust with her, cause I could like, she felt for me. So that's when I really opened up.

Instead of receiving a pill or a referral to a therapist or food bank, Shauna's provider gave her a bag of clothes, some gift cards, and their undivided attention. These actions exemplified, to Shauna, that the provider cared about her as a human and carried a willingness to step outside of the traditional role of the doctor. Such action directly combated Shauna's embodied fears of U.S. medical care, alleviating her feelings of unbelonging and mitigating the social stressors causing her daily hardship. Speaking with a tone of astonishment, or perhaps surprise, Shauna emphatically poses the question, "This is a doctor?!"

Ironically, this questioning brought her closer to her provider. Shauna and Margaret bring up a point about what clinical actions constitute normal biomedical care and what types of interventions im/migrants truly find helpful. Clinical interventions such as a pharmaceutical prescription or psychotherapy are the status quo, so against the grain responses that form personalized avenues to care stand out. This all begs an examination of how biomedical providers and institutions define and treat patient suffering. As Miriam Ticktin (2011, p. 3) describes, within the realm of biomedicine, "Suffering is recognized and responded to by looking to the biological body and is apprehended through medical and scientific techniques and rationales, which are considered universal and objective." However, in terms of im/migrant suffering, the facts do not lie solely in the body, nor can the distress of suffering only be alleviated through physiological, medical intervention. Further, this suffering is compounded relative to the trauma and adversity im/migrants often endure.

The responses of Shauna's provider exemplify this. Shauna's suffering could not

be helped through the biomedical manipulation of her body. Instead, ensuring her well-being required a holistic approach, one that treated Shauna's body as not simply biological, but as a biosociocultural entity. Andress and Purtill (2020) argue that providers learn to shift their medical gaze "from the body to the body in a place." The medical gaze, according to Foucault (1973), refers to the way providers *see* and think about patients, disease, and illness. As Andress and Purtill argue, this gaze needs to move beyond the biology of the human body and consider the body's environment. Furthermore, sickness is not simply bound to detrimental effects on the body. Patients also suffer from "illness problems" (Kleinman, Eisenberg, and Good 1978)—the daily difficulties for the living sick. As bodily functionality reduces, minor acts become troublesome, and to a larger degree, the ability to fulfill one's social roles and obligations are strained (Dossa 2009). For im/migrants, a patient population that already faces structural stressors which make life more difficult, it is paramount for their providers to ask them about the struggles of coping with daily life. *How do larger structures affect an im/migrant patient's suffering, and how can I, as a provider, best mitigate the causes and effects?*

Medical schools do not teach students to prescribe a bag of clothes or gift cards. But sometimes these holistic solutions help patients the most. They intersect into their daily lives where suffering is most often felt. Shauna, with a little less worry about her finances, could buy warm clothes and other essentials. And the addition of a Dunkin Donuts gift-card—which correlates with her "addiction" to the establishment—displayed to Shauna that her provider is invested in her life and listens to the small details she

shares.

But beyond that, Shauna's provider exhibited that they would not betray her trust. Judgment was non-existent, and Shauna, a person living and embodying a life of fear common across the unauthorized, felt she could open up without negative repercussions — “the experience of feeling absolutely safe” (Holland and Stocks 2017). Shauna's provider, whether aware or not of the greater social forces related to her homelessness and financial difficulties, did not judge Shauna or cause uneasiness relative to her decision-making. Instead, they provided tangible, *Shauna-centered* interventions that not only mitigated some of Shauna's suffering and embodied fear of medical care but also united the two on a deeper emotional level.

In sum, the key to trust and communication with im/migrant patients is empathy and understanding. The loss of agency at the hands of state actors and the embodied fear of governmental institutions warrants care that care is gentle, considerate, and respectful. Consent is paramount, and so is the willingness to be actively attentive. Taking the time to listen, ask questions, and determine a solution that fits everyone's preferences is advantageous. Friendly chatter is welcomed, and often im/migrant patients find this relaxing and helpful for building rapport. Moreover, trust and communication arises from patient-centered care. Engaging the patient, including them in care, and determining what they really need leads to better treatment outcomes (Gotler, Kikano, and Stange 2001). The result is treating a body in social and ecological space rather than only a biological entity. While the body may need intervention, the stressors of daily lived reality require alleviation as well. As Sir William Osler wrote, “The good physician treats the disease;

the great physician treats the patient who has the disease.” When the provider decides to treat patients rather than pathology, there are many possibilities for advances in the quality of care.

CHAPTER SIX: INTERPROFESSIONAL COLLABORATIVE CARE

“Alone we can do so little, together we can do so much.”

- Helen Keller

One clinic that holds a crucial role within BMC’s Im/migrant Health Center is the Boston Center for Refugee Health and Human Rights (BCRHHR). Founded in 1998, BCRHHR specializes in the delivery of medical and social services for refugees, asylum seekers, and survivors of torture. In order to address the unique needs of these im/migrant patients, BCRHHR brings together a team of physicians, social workers, case managers, and community health workers specialized in the care of this patient population. Thus, at the heart of BCRHHR’s operations is collaborative care. To learn more about what patients think of this interprofessional team environment, I asked Margaret, who receives services at BCRHHR, about her experiences regarding numerous people working together to provide her with a variety of services. Her response caught me off guard, and it made me reconsider what collaborative care means.

***Margaret:** I had a team myself. I had a team. We used to come sit as a group and then we start drawing things like this, making things with our hands, trying to, you know, make our minds forget. Though, sometimes it couldn’t go. But meeting together, and then we, we talk to each other. ‘Oh, you passed through this.’ We feel for each other, all of us [...] Yes. So, you find it helps, yes. Coming together as a group and we, sometimes we eat food. Sometimes we do something with our hands.*

Rather than considering and discussing collaborative care relative to the different providers she comes into contact with, Margaret formulates team-based care through a lens of group-care. Her care team is her fellow patients. The clinical and social service professionals, on the other hand, are simply facilitators who assist her and the other

patients with the goal of helping each other heal. Such an example challenges the meaning of collaborative care and hints at questions about who should be included in such teamwork. Care teams, perhaps, are not limited to other clinical professionals or services, but all who help patients heal and manage their health, including other patients.

In this chapter, I discuss the significance of collaborative, interprofessional care when treating im/migrant patients, and my contention is that the legal, housing, and other social problems im/migrant face are often too complex for one clinical or social professional to help alone. Embodying a willingness and preparedness to collaborate with others and network care across sources of intervention is imperative. This is a theme every provider in my interviews mentioned, and it is apparent that most medical professionals understand they have limitations and need to work with others (Mayo and Woolley 2016). As one provider told me, “There are certain things where my hands are tied. I cannot do what I cannot do.” The matter at hand, then, is not whether providers need to operationalize collaborative efforts; it is how and with whom.

Moving forward, I discuss what it means to collaborate, and why collaborative efforts are necessary when assisting im/migrant patients. Here, I outline five essential components of effective collaboration, and I maintain that addressing the plethora of structural stressors im/migrants face demands a team-based approach to care. Based on my interviews and observations of resident precepting, I briefly introduce and examine the different individuals and professionals involved in the delivery of im/migrant and refugee care. These include but are not limited to immigration attorneys, community health workers (CHWs) and patient navigators, actors in community-based

organizations (CBO), healers in other medical systems, and most importantly, patients themselves. To reiterate, my argument is straightforward: It is imperative any professional providing a service to im/migrant patients be inclined and equipped to collaborate. My goal, in accordance and henceforth, is to describe and expand on what this means and looks like.

Care and Collaboration for Treating Im/migrant Patients

At its most basic, collaboration means to work together with others towards a common goal. It entails an acceptance that one entity cannot solve a problem or deliver a service alone; “an effort to integrate and translate themes and schemes shared by different professional groups [professions] and the shared ownership of common goals, decision-making processes, and the integration of specialized professional knowledge and expertise” (Steihaug et al. 2016, p. 2). The desired outcome is a team, and within the realm of healthcare, this means different healing professionals, programs, organizations, and patients working together to achieve the goal of good health outcomes and positive healthcare experiences for patients. As Mayo and Woolley (2016, p. 933) write, “teams offer the promise to improve clinical care because they can aggregate, modify, combine, and apply a greater amount and variety of knowledge in order to make decisions, solve problems, generate ideas, and execute tasks more effectively and efficiently than any individual working alone.”

Five essential ingredients for team success

But, what does effective collaboration entail? Ultimately, clinical collaboration is only effective if done correctly. To help answer this question, Bosch and Mansell (2015)

use competitive sports to formulate *five essential ingredients* for interprofessional collaboration in health care. I chose this model in particular because I believe the team-centric nature of sports can prove beneficial in clinical settings. Team sports are about comradery, support, and togetherness, and the ultimate objective to determine a formula for winning. While the practice of medicine is not about winning or losing, it is about success. Care teams working together and determining a recipe for consistent success is paramount in the provision of high-quality care delivery, and team sports have consistently represented how people can work together to accomplish a common goal in creative ways.

Role Clarity

The first ingredient is “role clarity,” akin to the distinct roles the players on a football team hold (e.g. the patient as the coach, the primary care doctor as the quarterback, or the social worker as the wide receiver). Each member of a care team, the patient included, has a designated, accepted role, and every team member recognizes the irreplaceable value that each team member brings. As one provider told me, “Although others may disagree, I think it is very difficult to turn a doctor or a NP or a PA into a social worker, housing expert, childcare provider etc. etc. etc.” Every professional involved in health care holds a distinct role, and it behooves everyone involved in healthcare to acknowledge the skills and knowledge other professions bring to the team. A doctor is not a nurse, a nurse is not a social worker, a social worker is not a chaplain, a chaplain is not a patient navigator. “Each expert adds a specific value, creating a collective synergy so that patient needs can be most effectively met” (Bosch and Mansell

2015). Moreover, every professional embodies particular forms of knowledge and competence, and the bodies of different professions operate within the U.S. health system in distinctive ways. Every profession holds particular merit concerning the collaborative treatment of im/migrant patients.

Including the Patient

Moreover, often no one knows how to best meet patients' needs more than patients themselves. Of course, a clinical or legal professional can help in ways a patient themselves cannot, but such assistance only comes at the behest of the patient, the holder of pain, ills, and experiences of structural violence. One primary care provider I spoke with alluded to the importance of collaborating with patients, telling me, "Our first collaboration is between us and our patients before anybody else. Before I refer to any other specialty. My first collaborator is my patient." Care begins and ends with the patient, who is not simply the source of informed consent but the key to effective clinical intervention. As Supper and colleagues (2015) write, "The active participation of the patient is required to go beyond professional boundaries and hierarchies [of care]." In this regard, patients are the experts in their own care. They know about the happenings in their life, their body, and what matters most to them better than anyone.

What is more, patients told me how their inclusion in their own care helps them build relationships with their providers and develop a sense of human acceptance. This, as Margaret says, gives im/migrant patients feelings of safety and freedom—of liberation.

Margaret: *They [providers] are telling us [patients], then you know, those words of comfort, then you feel you are free, ehh. You feel there is a freedom at least. You ask questions. That's freedom. Somebody's answering you. That's love, that's kindness, that's freedom. Somebody is taking his/her time to stand like you have,*

have taken your time, and I have taken my time, and we are listening to each other. Me, as an im/migrant, you know. An im/migrant is, who has nothing. But somebody is there. It has, it has made somebody strong. Feeling he is loved again. Not telling her or him you are not needed here or running away from something. He's safe. He or she's safe, because something is telling her or him that you are safe here. And she feels it, she says it, [slams the table] she touches it, and it is real. [pause] and it is real. It is real. It is real real. It is real real."

When the patient and provider are together in the same space, giving each other their full attention, patients develop feelings of freedom. "It's love, it's kindness." Through simply being with the patient and giving them the opportunity to express themselves freely and exist in their body without judgement, there is healing. Safety and benevolence overflows them, manifesting into visceral sensations emblematic of holding "real" freedom.

Further, as Margaret's other statement at the start of this chapter notes, these feelings of freedom and deliverance do not only come from the patient's inclusion in care through the provider, they also come from patients interacting with each other in efforts to heal. Margaret says that patients talk with each other about the "things they've passed through;" migration related experiences that, while infinite, are understood across patients as they share their stories. This is to say, while providers can learn about the health and social issues im/migrants face, only im/migrants themselves know what it is like to be an im/migrant—they are experts in the im/migration journey. Similar to the Alcoholics Anonymous program where individuals struggling with substance abuse share their stories and provide each other support, im/migrants need other im/migrants—people who share their own life trajectories, struggles, and identity—to help them heal (Kira et al. 2012).

To that end, “passing through things,” as Margaret mentions, may refer to the many ups and downs im/migrant’s experience—from persecution abroad, the relief of entry to the U.S., to the stress of managing life in the U.S. Concurrently, though, it could also refer to the many spaces im/migrants move through as they leave their countries of origin and cross borders into new environments and sociocultural worlds. Whatever the case, it is without question that im/migrants have distinct experiences and problems which require the help and healing partnership of other im/migrants.

Trust and Confidence

The second ingredient is “trust and confidence”. Like a quarterback would trust the offensive tackle to protect their blind side, healthcare professionals trusting each other to uphold the requirements of their individual roles, such as a PCP trusting a radiologist to properly read an MRI or a nurse to administer the correct medication dosage, is significant. This is easier said than done, however. Interprofessional trust-building takes time and personal connections, and as Bosche and Mansell (2015) note, rotating schedules and different professional settings make trust building across care teams difficult. One response clinics can incorporate is interprofessional proximity (Miller et al. 2014). In other words, the more time providers across specialties spend together, see each other at work, and include each other in care, the higher the likelihood that this will produce trust and collaboration. Indeed, a figure from a 2016 Office of the U.S. Surgeon General report titled “A Continuum of Collaboration between Health Care and Specialty Services” states the highest levels of collaboration occur when teams work in the same space (Office of the U.S. Surgeon General 2016).

One example of such interprofessional proximity, as I noted at the beginning of this chapter, occurs in BMC's BCRHHR and General Internal Medicine Im/migrant clinics, which are not simply places where im/migrant patients meet their primary care providers. These clinics also include on-site services from nurses, lawyers, legal navigators, counselors, social workers, and women's health providers, creating a clinical environment where numerous professionals deliver care in the same space.

This, as a few providers I spoke with called it, is an example of the Patient Centered Medical Home (PCMH). In this type of care setting, many different providers with different care roles operate in a single clinical space. Similar to the idea of a "one-stop-shop," this allows patients and families to receive almost all the services they need at one location. Moreover, as Baird et al. (2014) and O'Dell (2016) also note, the medical home helps patients achieve maximal health outcomes through the American College of Physicians joint principles of primary care—a personal physician, physician-directed medical practice, coordinated or integrated care, ensuring quality and safety, enhanced access to care or services, and payment. Consequently, PCMHs create more effective care coordination and information sharing across the care team, establishing teams not only imbued with trust, chemistry, and accord, but interprofessional collaboration that ensures effective communication about the patient's care and safety, something often lacking between healthcare professionals (Foronda, MacWilliams, and McArthur 2016).

COVID and Collaboration

In-person collaboration, however, has become scarce in the wake of the SARS-CoV2 pandemic, with many forms of clinical care and legal services now occurring over

telephone or remote video-conferencing platforms (Sasangohar et al. 2020). During my observations of resident physician precepting in the General Internal Medicine Im/migrant Clinic, this was apparent. For one, the sessions themselves occurred over Zoom, nullifying any form of in-person collaboration not just with patients, but amongst the residents, attending physicians, and other providers. Time after time, residents had trouble moving between the Zoom session with the attending physicians and the phone calls with their patients. It was no longer as simple as walking to another room. Moreover, telemedicine also resulted in difficulties figuring out three-way calling for the purpose of including interpreters. Even when residents were able to access linguistic interpretation, they reported poor audio quality that resulted in problems communicating with patients. To that end, residents also noted occurrences in which they could not communicate with other providers, such as counselors and social workers, as they normally would. Furthermore, when a patient needed to consult with a legal navigator, patient advocate, or any other provider, such services could not be delivered as normal.

All this said, residents did not frequently mention major difficulties collaborating with their patients. While there were occurrences when residents could not reach the patient or felt stuck about what to do because of the inability to conduct physical examinations or see their patient eye-to-eye, I rarely heard complaints related to the task of remote care. The only significant observation were times when a patient was hesitant to speak over the phone with a provider with whom they had never met. In agreement, another study conducted by Drs. Mattar and Piwowarczyk at the BCRHHR states that many of their patients have been hesitant to communicate with providers through

telephone (Mattar and Piwowarczyk 2020).

The Ability to Overcome Adversity

Bosch and Mansell's (2015) third ingredient is "the ability to overcome adversity". Similar to an interception or fumble in football, there are times when care does not transpire as providers and patients foresee. In these crucial situations, it is paramount that all members of a care team work together to determine a solution and ensure the wellbeing of the patient. "Challenges require every [team] member to remain committed to the ultimate goal, which in the case of health care is patient care. Since adversity is something that every team in any setting will inevitably encounter, it is imperative that health care providers working collaboratively become adept at dealing with it effectively" (Bosch and Mansell 2015, p. 177).

One particular story a provider shared exemplifies what it means for a care team to collaborate and overcome situations of clinical adversity,

[There] was a patient who came to the U.S. for medical care [...] So, when I met her she was finally ready to talk about her legal status and eventually she and I had a conversation with an attorney over the phone in my office where she found out not only she has no pathway because medical care isn't a reason to be in the U.S. and is not, is not reason enough to get you legal status in the U.S., so she was also undocumented. She did not know her visa had expired. So, she panicked and it was like a really tense moment for the two of us, but also one where I realized if she had been at this attorney's office she would of been in a strange place, she would of had to go home in an unfamiliar route she would of been like confused and wouldn't of had somebody to sort of debrief with. But here, she debriefed with me about the legal situation. She immediately saw a counselor to be like, 'Hey you are stressed out. Here are some strategies to help you when you are stressed out and scheduled like a bunch of follow-up appointments.'

In this situation, a primary care provider (PCP), immigration attorney, and behavioral health counselor came together to assist an im/migrant woman dealing with

both health issues and immigration insecurity. Rather than the provider team crumbling under the adversity—intensity—of the moment, they collaborated to ensure the patient had the support she needed. The onsite immigration attorney communicated the patient’s immigration situation to other members of the care team, the PCP stayed with the patient and helped coordinate next steps, and the counselor assisted the patient with managing her stress. Together, the team was able to surmount this unanticipated situation, delivering collaborative healthcare services that eased the patient’s uncertainty and put in place required legal and behavioral health services moving forward. These types of collaborative efforts in the face of adverse circumstances are necessary when treating im/migrant patients.

The Ability to Overcome Personal Difference

The fourth ingredient Bosch and Mansell (2015) recommend is “the ability to overcome personal differences.” While conflict is a normal part of collaboration in any setting (Tekleab, Quigley, and Tesluk 2009), differences related to clinical approaches, provider backgrounds, and the stakes of ensuring patient safety makes dispute within care teams a unique and delicate circumstance. As such, care teams possessing an inclination to resolve disagreements and move forward together for the sake of delivering quality care is crucial. To that end, dispute about how to treat a patient and decide on interventions is not inherently bad, and all providers on a care team should view disagreement as an opportunity for optimizing their care potential. Disagreement means different viewpoints, and as Bosche and Mansell (2015) write, this “can bring about different viewpoints and facilitate innovation and problem solving.” One provider I spoke

with framed it like this, “The point is not to eliminate other people's ideas but really work with them.”

Intergenerational Conflict

However, disagreement and dysfunction does not only occur among providers. There may be conflict within the patient’s family, another key part of the care team, that is related to health and illness. One provider I spoke with, a pediatrician, mentioned the significance of intergenerational conflict when treating their im/migrant patients, which is so pervasive across im/migrant families that scholars consider it “a normative experience” (Choi, He, and Harachi 2008). Intergenerational disconnect, while the result of different upbringings between parent and child after migration (i.e. foreign-born parent and U.S.-born child), also concerns parental trauma and its negative effects on im/migrant children's behavior. Indeed, Case and Paxson (2002) outline how problems with a parent’s mental health can cause a detriment to their children, and further, Sangalang and Vang (2017) have found evidence amongst refugees of “parental trauma transmission on descendants’ [children’s] health and well-being.” As a result, when treating pediatric im/migrants, the focus of attention may often need to be on the parent. A delicate scenario in which the provider and parent have a difference of opinion about the cause of a child’s health problems, the parent themselves. The pediatrician I mentioned above told me a story where they and the staff at a patient’s school intervene with a patient’s mother,

I have a kid [patient] who, from an im/migrant Brazilian family. The kid, I think, was U.S. born and mainly the mom, just, she had issues. Some of them were cultural, some of them were her own mental health issues, and the kid was rebelling against it and getting angry. And the parent will call the police, take the

kid to the E.R, and everyone is focusing on the kid and his angry outbursts and we're all thinking like, 'Jeez, if I was that kid I'd probably be responding in the same way', and eventually we were able to turn the focus on the parent. Like, my staff and I've worked with the kid's school to get the school to, I think they filed a 51A and sort of got the focus shifted. When, you know, a 51A is a complaint against a caregiver it is not just a general allegation of some kind of abuse. It is a complaint against a caregiver specifically. So, by the school filing a 51A, because the kid was missing school a lot, they were able to get services focused on the parent and start the process in shifting the focus of dysfunction away. The recognition that the focus of the dysfunction was not coming from the kid, but that the kid was responding to the parental dysfunction. Right. And eventually things got diffused enough that the kid basically was able to sort of get on with being a kid and not being told he had anger problems or mental health problems as everyone who was involved was able to sort of recognize that it was the parental dysfunction compounded by cultural issues that was leading to the kid feeling helpless and responding dysfunctionally, you know, through anger and outbursts and, you know, physicality [...] The kid kept saying that you know my mother is the problem. 'She is such an idiot', right, you know, typical teenager. But it was, you know, people giving her the benefit of doubt. She is telling a different story to the emergency providers in the E.R. or B.E.S.T. (Boston Emergency Services Team) or whatever, and you know, giving her perspective on it and her perspective was tinged by her own you know mental health issues and her culture so it just adds that extra complexity to it.

Here, the physician and school staff had to take action to ensure the social welfare of the pediatric im/migrant patient in spite of the parent. The patient was not getting to school and the home environment was chaotic, which created a vicious circle of social dysfunction. This, of course, is not inherently the fault of the mother. She did not choose to have behavioral health problems. But when im/migrant parents and providers (including school staff) have differences of opinion that stems from a parent's im/migration trauma, it is evident that care may need to be directed towards the parent and some responsibility taken from their shoulders. To that end, the goal is not to punish im/migrant parents whose traumatic experiences have caused behavioral and/or parenting problems. They need help, not punitive action.

In this scenario, however, one could argue that personal difference was not necessarily overcome and that the actions of this provider could have allowed the state to bring a formal charge of abuse against the mother. Moreover, the mother and provider did not come to an agreement, and this healthcare professional and the school staff did what they thought needed to be done by submitting a 51A complaint to the Massachusetts Department of Children and Families. Such a decision should not be taken lightly. The point is personal difference across providers and im/migrant families is about coming to a conclusion that is best for the patient, whether or not everyone on the care team, including parents, agrees. This is especially difficult when trauma, acculturation, intergenerational, and mixed-status differences are frequently present amongst im/migrant families. Moreover, such an example could also extend to situations of treating elderly im/migrants or im/migrant patients with cognitive disabilities.

Collective Leadership

The fifth and last ingredient is “collective leadership,” which Bosche and Mansell describe as the shared commitment to team goals, standards, and values. This manifests an environment where everyone on the care team understands they are only as strong as the weakest link; a belief that each team member is only as capable as those they are surrounded by. For this reason, there is a need for providers who work with im/migrants to support each other, especially in consideration of secondary trauma, which may emotionally damage providers after hearing traumatic stories. On this matter, one behavioral health provider had this to say,

When we, as trauma focused cognitive behavior therapy there is child-parent psycho-therapy. There are all kinds of therapies that are evidenced based, let's

say, to be able to work with young children and children across the age range who have experienced trauma and families who have experienced separation. But you have to have to have training. You have to have supervision, you know, reflective supervision about how to work in these populations without being, you know, stressed and vicariously traumatized yourself. You know, reflective supervision is something we talk a lot about where people can talk about cases but also get support around their work because it is very hard. So, I think that needs to be, that is something else we have to have...Support for the providers and the forum to case discuss and reflective supervision and support, and I think this is part of the team approach, and that there is collaborative team supervision as well as the opportunity for reflective supervision and support and working with these populations.

It is without argument that some im/migrants come to and live in the United States with traumatic experiences that have left them with physical, spiritual, and emotional scarring (Perreira and Ornelas 2013; Peña-Sullivan 2019; Steel et al. 2009). Whether due to physical torture, family separation, constant worry about being deported, or otherwise, these experiences leaves damage on the im/migrant body and spirit. In response, it is often up to U.S. healthcare providers to help these im/migrants recover and rebuild their health and wellbeing. What sometimes results from these efforts, however, is damage to the provider's own welfare; a hurt that comes from a transmittance of traumatic experience. As providers working with im/migrants become exposed to traumatic stories, the trauma can become a vicarious part of them (Barrington and Shakespeare-Finch 2013). Subsequently, the collective leadership of care teams treating im/migrants is about support, and as the provider above says, reflection. It befits everyone involved in this realm of care to talk with each other about their struggles, emotions, and thoughts.

Professional Humility

In sum, clinical collaboration when treating im/migrant patients requires

professional humility relative to one's cultural formation as a clinician. To put this another way, providers recognizing that they do not have all the answers or abilities is critical to the collaborative action, and this recognition comes from an acknowledgement that one's professional training and personal background limits capabilities and worldly perceptions.

You know, I think that if I had to pick two things I would think probably it would be, to be a better provider, you know, you can only provide really good im/migrant care if they [providers] realize that it is not just the same thing taking care of patients who are not im/migrants, so they kind of have to have the knowledge that there are all these other skills involved and if you do not know that about yourself then you won't know to, just you know, help to get better. I think just self-assessing like what do you know and what do you not know. I think that is really important.

Professional training or schooling, whatever the occupational area, provides a delimited amount of knowledge. Further, one's personal background, experiences, and understandings of the world cannot account for that of everybody, professional colleagues and patients included. There is a need for providers to strive for and appreciate collaboration; to hold a professional humility relative to one's skills and understanding of care, healing, and human perception.

Why is Collaboration Necessary When Treating Im/migrant Patients

As I discussed in the background and structural competence chapters, im/migrants are subjected to many different types of structural violence. The historical construction, arrangement, and organization of U.S. social structures put im/migrants into situations and circumstances that hurt their health. To put it bluntly, U.S. social structures make im/migrants vulnerable, and as a result, there is a superfluity of potential causes of an im/migrant patient's illness, worries, and strife. This, in itself, necessitates the use of

differing professionals across the spectrum of social structures. Immigration dilemmas require an immigration attorney and/or legal navigator. Food insecurity requires coordination with personnel in food banks/pantries, community gardens, or other food access resources. Housing problems require a housing advocate and/or lawyer. Absolutely, the problems im/migrants present to providers are simply too big and the solutions too diverse for one person in one profession to help alone. Providers and clinics building a network of available interprofessional resources for collaboration, as one primary care provider noted, can be helpful and boost a provider's confidence about question asking.

Well, I think what is hard with working with people from other countries is it can be overwhelming when you realize you don't have the expertise that they are looking for. A lot of patients come into their primary care doctor appointment and they have questions about all sorts of things. Like housing, food services, legal services, a range of things. I think something that I have learned that is important is recognizing when to ask somebody what is going on and what they need assistance with and when to know when you are not the right person to answer their questions. So, it is kind of a combination of gathering the information, understanding what is going on with the person, but not taking on more than you can actually do. And I think it is hard to ask those questions if you don't know where to go for the answers and that's part of the, you know, what this program (BMC Im/migrant Health Center) is and making sure there are places for them [im/migrants] to go. So, I think it is a little about developing your knowledge about where people should go, what resources they are available to. But it is also about collaborating with your team to make sure you are not taking on too much and also not falling into 'I don't have the answer, so I shouldn't ask them the question.'

When a provider knows where to direct a patient or where to ask for help, there is a greater inclination to ask the patient questions. As the provider above alludes to, a lack of awareness leads to a lack of inquiry. After all, a question without the skills or connections for resolution is an empty gesture. However, a provider can mitigate

reticence and strengthen communicative abilities when aware of potential interventions beyond their scope of practice. Because, in actuality, there are services and resources available for im/migrant patients. The key is a semblance of balance between understanding the problem and acknowledging another professional, organization, or program is better suited to help or answer questions.

Regarding a balanced knowledge of immigration law resources, one primary care provider put it like this,

Providers have so much to keep up with that it's good for them to have some vague knowledge of legal stuff, but that can't, we can't expect all of them to be immigration legal experts. And, I mean, you know, I feel like in the role I've been in, I've learned a lot, but I still would never, you know, I would always say, 'Go talk to a lawyer, I can't give you advice on this,' you know. So, I think, you know, we can educate providers to the extent that we can, but really just making sure they know where people might be able to go because there are these resources like free legal clinics all around Boston. So you know, just making sure people [providers] are aware of what the resources are that are out there.

Im/migrants Move Between Different Social Institutions

Notwithstanding, the social adversities that necessitate clinical collaboration when treating im/migrant patients is not just about social structures and their operations alone. The accompanying predicament for providers is that the im/migrants they treat are at a nexus between multiple interconnected social systems and institutions. There is im/migration, housing, social services/public benefits, education, healthcare, and more. There are just too many structurally informed systems with distinct policies and procedures that im/migrants may interweave with. This presents a need for having a network of professionals with different types of knowledge about U.S. policies and institutions. Again, speaking relative to immigration policy, another provider told me,

I do think that some sort of knowledge of the immigration process, of the kind of complexities that im/migrants have to deal with. The bureaucracies, the multiple institutions that they have to go between, I think that kind of knowledge is helpful [...] I think im/migrants struggle, one they struggle like everybody else depending on their particular status. But then there is added layers of sort of exposure to deadlines, to losing one's status. I mean, you know, the temporary protected status shifts that have affected Salvadorians and Haitians in Boston, then the reversals of those policies and reinstatement of those policies kind of keeps you on a yo-yo. And it changes how you approach what is important. 'What do I [the patient] need to maintain? How can I figure out how to stay here even if my status is lost?' I have run into a lot of people who are trying to figure that out, you know. 'Is my status going to, am I going to remain in this temporary protected status or am I going to have to try to shift status and how do I do that? That becomes a huge problem that occupies your mind [the patient's mind] constantly.

These questions the provider above presents are genuine inquiries that im/migrants have due to the ever changing policies of the U.S. immigration system. As they say, there are structurally informed “layers” that create a cycle of instability and uncertainty in im/migrant lives. In response, it appears necessary that providers maintain a level of knowledge that keeps them informed about government policies and assemble a web of professionals for referral who can help patients navigate the changing nuances of U.S. laws and policies. People who have the skills, know-how, and expertise to help solve these common and significant im/migrant patient questions and dilemmas.

Who Should Providers Collaborate With

Legal Navigators and Attorneys

As the two examples above note, legal knowledge and resources is a paramount aspect of delivering adequate care to im/migrant patients. Often, these patients have questions, concerns, and needs directly connected to the immigration legal system, which requires specialized assistance. After all, like one requires a medical practitioner for

health services, one requires a practitioner of law for legal services.

Within BMC, immigration related concerns are delivered by legal navigators and attorneys, both of which providers in my interviews discussed on numerous occasions. Legal navigators, while not legal practitioners themselves, help im/migrants access legal resources and navigate immigration situations. A study conducted by BMC's IRHC clinical leadership (Kimball et al. 2019) found that over the course of one-year, the legal navigator assisted 271 patients and helped patients navigate a multitude of immigration-related scenarios, including support for asylum (35%), green card access (21%), citizenship (5.2%), medical deferred action (1.5%), deportation defense (0.7%), supportive documentation such as a forensic affidavit or a medical disability waiver for citizenship (22.5%), and general immigration questions (10%). While the legal navigator was not able to help every patient with their immigration problems, there is little doubt specialized personnel who can help address immigration related needs in the clinic improves care outcomes. Moreover, with the ever changing nature of immigration laws and policies, as BMC's legal navigator told me themselves, it benefits having specific individuals who can keep track of, disseminate, and provide patients immigration information and resources.

I have my own database. I try to keep track of it and update it so that when policies change at organizations I know how to advise patients, and I think that is something that can be helpful if there is communication among a team. It can be distributed or updated collectively. Only having one person actually doing the work of keeping track of that makes it so it isn't a huge time waste for everybody.

Rather than having to assist patients with and stay up-to-date on all immigration law matters and organizations, providers can refer services to legal navigators. To that

end, as the legal navigator noted, this ensures that patients receive information from the right people. An immigration attorney I spoke noted their major concern is im/migrants receiving wrong information or advice.

Immigration law is so complex that it is my, it is our [their legal clinic and staff's] full-time job, and it is very difficult for us to keep on top of it with all of the changes. So, it's just very important for providers to think of, you know, lawyer collaborators as, to think of themselves as, 'I need to make a really excellent referral and identify, you know, what this person is going through and get them hooked up with the appropriate resources.' Because, there have been some instances where people want to help and end up hurting more because they're not aware of a certain change that just came about in the law or they think a process is very simple and they help somebody fill out a form or something and then it, they end up, wind up putting that person on the path of the deportation machine and stuff like that [...] So, it's important to have those relationships with lawyers and with other, you know, people who are informed. You know, immigration workers who are keeping on top of these things to make sure that no one would ever want to harm their patient by giving the wrong kind of help or giving advice that was inaccurate or something like that.

As such, it is significant providers treating im/migrants concede immigration related matters to the proper professionals who have specialized knowledge of immigration law. When this occurs, the worst that happens is the correct people are unable to assist the patient. Conversely, if a healthcare provider decides to give patients advice or information on immigration legal matters themselves, the repercussions could be much more grave. What needs to happen, as the legal navigator and immigration attorney indicate, is a coordinated network of immigration law professionals and paraprofessionals who can communicate with clinical personnel and assist patients as required.

Our immigration navigator has helped a lot of our families and our patient navigators in pediatrics have been trained to do some of the front line immigration referral that has been incredibly helpful [...] Then support around

basic needs with immigration referrals has also been really helpful through the medical legal partnership of being able to connect patients who need help with immigration on the legal side to appropriate resources.

Providers can refer patients to legal navigators, and from there, patients can be directed to the appropriate legal resource, such as an attorney. This ensures that patients get the immigration legal support they require through effective collaborative action. As the pediatric provider above suggested, this set-up works.

Collaboration Beyond the Clinic: CHWs and CBOs

Moreover, the examples above point towards collaboration that moves beyond the clinic. Intervention is limited when collaborators only work in clinical settings, and to that end, it appears engagement in im/migrant communities—where patients spend their day-to-day lives—can prove helpful in effectively ameliorating the structural and navigational problems these patients face (Turin et al. 2020). This means integrating community health workers (CHWs) and patient navigators who can intervene and assist outside of clinical spaces. As both Islam et al. (2017) and Shommu et al. (2016) determined, putting in place healthcare personnel who have community-centric roles improves health outcomes and experiences for im/migrant individuals. Such paraprofessionals are able to help with hurdling navigational tasks such as scheduling and getting to appointments, picking-up prescriptions, and applying for public benefits. Further, they also act as cultural brokers who can help aid and facilitate communication, education, and trust with im/migrant patients.

I think the community health worker piece comes in to be very, very important [...] community based support people who actually kind of went out and helped engage people or helped them navigate things they needed and support them [...] Just having out-reach you know, being able to see people and their community

and re-engage them, I think that helps. If people come and see people like them that speak the language and that there has been some level of trust, then they are more likely to come. That is the other thing with the refugee organization (BMC IRHC), like a lot of the staff are a refugee background themselves and know the other countries and places people are coming from, speak the language and so people have a little sense of comfort. They have been helped in different instrumental ways and so it is a little bit of trust but we are finding even the community health workers are having to do a little more outreach and things like that to maintain that sense of safety because people are really on edge.

However, community engagement interventions should not stop with CHWs and patient navigators. Instead, as one provider noted, engagement with im/migrant-oriented community organizations—“community-based services or supports, faith-based organizations, and mutual assistance associations [...] the different players and resources available to them [im/migrants]”—is helpful. Efforts to work with organizations in the community, whatever or whomever that may be, improves patient health outcomes (Bloemraad and Terriquez 2016). In doing so, collaboration may extend across the community, where providers and clinics can reach a variety of actors, activists, organizers, and professionals for mutual assistance and support.

“CBOs [community-based organizations] can produce individual-level health benefits by fostering civic engagement, psychological efficacy, social relations, a sense of solidarity and collective identity. We make the further claim that attention to somewhat formalized groups—ones that have some history, collective identity, and ongoing social relations in common spaces over time—also elucidates how individual action can produce change in the structural determinants of health” (Bloemraad and Terriquez (2016, p. 221).

To put this simply, CBOs make their own significant contributions to the community and are intimately involved with combating social disparities. They know what they are doing, or as another provider put it, “community organizations are on top of what’s happening [...] they understand what people [im/migrants] are facing.”

Providers and clinics working with im/migrant patients may find forming partnerships with community stakeholders advantageous. This not only creates a breadth of available resources, but puts in place a foundation for collaborative possibilities moving forward.

Moreover, in terms of capital, collaborative efforts with CBOs engages the many community assets of im/migrants. Rather than taking from these organizations and resources of social support, building their capital—influence, strength, and utility—can result in greater forms of communal empowerment and health. Furthermore, this also recognizes the conduct of im/migrant bodies in their community, where they are not passive individuals but collaborative bodies working in socioecological spaces to improve and uplift their own lives. In any endeavor to work with the community, providers and clinics nurturing communal organization and agency is significant.

Working Across Ethnomedical Systems

A notable aspect about health services in the U.S. is the availability of many different types of healing modalities and ethnomedical systems. As Kirmayer (2004) brings attention to, beyond biomedicine, there are a plethora of different health and healing systems for people to choose from and interact with. One could seek care not just from MDs, DOs, NPs, and PAs, but also a shaman, homeopathic provider, and acupuncturist (providers of complementary and alternative medicine (CAM) practices). The combinations are seemingly endless, and as a result, there are grounds for biomedical providers to be mindful of the medically plural environment they and their patients live in, especially when the patient is an im/migrant.

While many U.S.-born citizens use forms of CAM themselves (Barnes, Bloom,

and Nahin 2008), these medical practices are often “part of indigenous systems of healing from the Asian, African, and American continents” from which many U.S. im/migrants originate (Elewonibi and BeLue 2016). As a result, im/migrants brought and continue to bring these practices and beliefs with them—a migration of healing traditions—and they subsequently use CAM services at a higher rate than U.S.-born individuals and are more likely to seek them out before “conventional” medicine (Elewonibi and BeLue 2016). In short, CAM systems and practices may be significant aspect of im/migrant patients’ clinical realities, and therefore, it appears necessary that biomedical providers engage with and be receptive to the ideas of other types of healing methods. Hence, it is significant providers recognize they and other members of the biomedical system may not be the only healing professionals providing their im/migrant patients a health service. One provider I spoke with framed it like this,

I would say another thing is, and I think this is something that we [clinical educators] have tried to do in various forms of training, is to help providers understand that they are only a piece of someone’s health system. They are not the whole thing and may not even be the primary provider of care. There may be other healers in the community, other people who are consulted for health advice who may be more important in a person’s health system than a primary care or E.R. specialist provider.

As a result, healthcare providers may find it useful to ask their im/migrant patients about other healing professionals who may be delivering them a form of medical care. This is to embody of a collaborative curiosity—a genuine desire to work across and learn from professionals in other medical systems. As the provider above continued to note, this often mitigates im/migrant patients’ concerns about a provider’s willingness to believe them about their health and illness perceptions.

Why would I [the patient] bother telling you [the provider]? You don't have the expertise. You wouldn't believe me, and you wouldn't be able to do anything about it. So, I need to find somebody that does believe me and somebody who can do something about it, and I think that is the challenge for the providers, is to say, 'What else are you doing, you know? What, what kinds of things have you tried? Are there other people who are caring for you? Is this something you can talk about with family or friends? Or, is this something you don't want to talk about with them?'

Therefore, when a provider is open-minded enough to learn—ask the patient—about other healing modalities they may be using, an impression is left on the patient. Rather than feeling as if the provider will write-off one's beliefs, decision-making, and rationale relative to a medical problem, the patient feels an inclination to share and trust. Furthermore, this entails that providers do not hold any judgement towards a patient's hierarchy [patterns] of resort. First introduced by Schwartz (1969) and then expanded on by Chrisman (1977), hierarchy or patterns of resort is a theoretical construct that formulates decision-making during illness as a stepwise process; there is an order to how illness [health] decisions are made, and that a certain socioculturally informed rationality follows suit. 'When the first treatment does not work, go on to the next. Then the next.' With this in mind, biomedical providers may not be the first healthcare professional in an im/migrant patient's order of seeking care. When this is the case, instead of responding with negativity, judgement, and discord, these are opportunities for providers to be open-minded and collaborate with the other healers the patient sees for care.

Further, Young's (1981) discussion of rationale during illness may prove helpful as well. The heart of Young's argument is that rational thought is non-objective, but rather "embedded in actions, social relations, and material equipment" that collude with any single decision that one can make. Rationality is one's own socioculturally informed

mental processes for responding to stimuli and organizing information and knowledge. At the end of the day, there is no one rational decision nor one rational form of decision-making when sick. As Garro (1998) thoughtfully put it, interpreting illness decision-making and rationality is to “understand the reasoning process and not to assess whether reasoning occurs in the right way.”

Im/migrant Care Needs To Be Networked

This [im/migrant] care must be networked. So, you can't think of yourself as operating as a lone clinician or even a lone clinical team. If you map out the care of these patients, it usually involves a large network and it should involve a large network [...] And you need to understand the local context of who's available to participate in this network, what resources can they bring and how do they help your patients.

In sum, it is imperative that care delivery for im/migrant patients, as the provider above told me, is networked. There are too many pieces of im/migrant health that need addressing, and to that extent, too many additional sources of support and communal capital for providers to ignore. Effective clinical care comes from recognizing that the best possible results do not come from solo acts—as a lone body—but from the work and efforts of multiple actors—bodies—across multiple socioecological spaces.

CONCLUSION

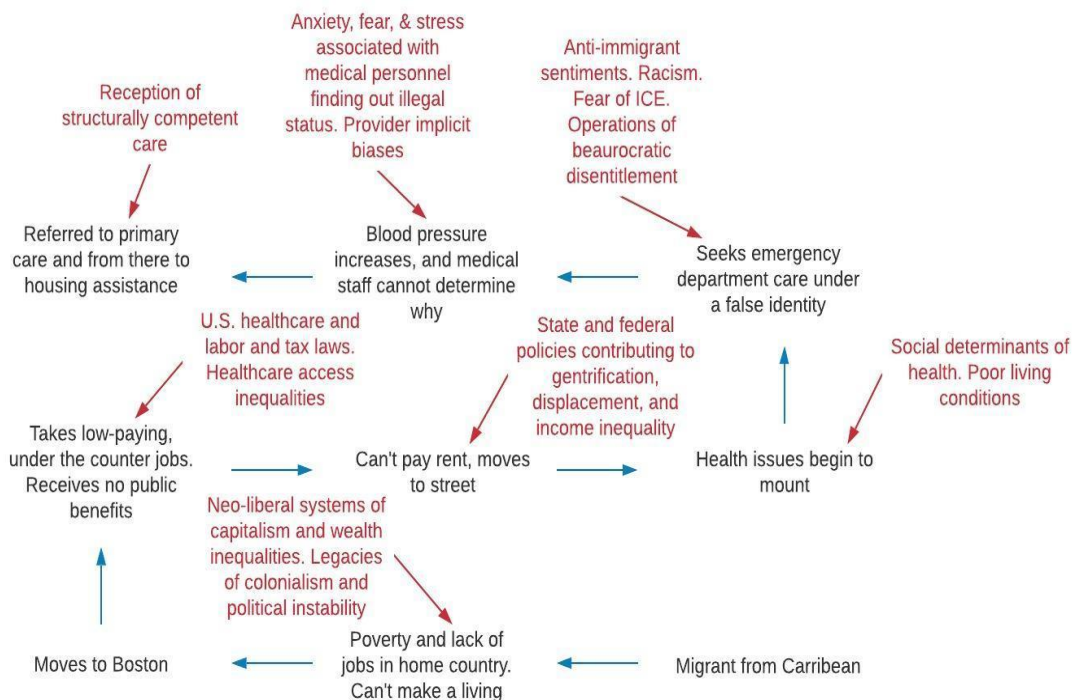
The primary argument of my thesis is that excellent, high-quality care for im/migrant patients arises from acknowledging and understanding immigration as a social and structural determinant of health in its own right. Im/migrant status, regardless of the specific type, affects many aspects of life and being.

As migration flows increase worldwide, the social determinants of health surround the many individuals who choose to or are forced to leave their homelands for survival, work, safety, and, in some cases, a new home in another land [...] Whether voluntary or involuntary, migration poses challenges to individuals and communities, requiring an almost complete realignment of daily life that can have significant social, economic, and health consequences (Castañeda et al. 2015, p. 376 & 377).

As such, im/migrant health clinical practice and provider attainment of clinical competence for this specialization, is rooted in knowledge and the implementation of interventions that combat the larger structural, cultural, and political forces that make life difficult for this patient population.

To further support this argument, I circle back to Shauna whom I mention in the opening of and throughout my thesis. On the following page, I provide a concept map of Shauna's journey (adapted from Neff et al. 2019 & 2020). Moving from the Caribbean to Boston, she faced hurdle after hurdle, eventually becoming sick and homeless. She decided to seek emergency room care under a false identity, resulting in a rising blood pressure that her providers could not easily resolve. Whereas usual biomedical approaches may frame Shauna's life trajectory as the result of behavioral choices and/or the work of biology and genetics, structural analysis of her medical problems displays that the problems are bigger than herself.

Figure 7.1: Shauna’s migration journey (adapted from Neff et al. 2019 & 2020)



In her home country in the Caribbean, Shauna faced unemployment and poverty, symptoms of neoliberal economic policies and legacies of colonialism which underpin the operations of structural violence and vulnerability. In response, she decided to move to Boston alone as an unauthorized im/migrant, avoiding legal avenues because she did not meet the criteria for refugee/asylum status, family reunification, nor specialized occupation. Upon arriving and living in the U.S., because of income tax and labor laws, she was forced to take under-the-counter jobs that barely made ends meet and supplied no employee benefits. Moreover, as noted by an inter-agency United Nations High Commissioner for Refugees report (Inter-Agency 2001), such struggle is also connected to xenophobia, racism, and other sociocultural belief systems that inform and reinforce

such governmental policies. This also includes American, neoliberal economic beliefs that reject universal health care and prevent medical access to patient populations such as unauthorized im/migrants.

As a result, Shauna was unable to pay her rent and lost her housing. Shifting between the street and friend's couches, the unstable living conditions began to take a toll on her health. Unable to stay warm, bathe, eat, and comfortably sleep on a consistent basis, her body and sense of self-worth began to deteriorate. Further, as Shauna explained, she felt trapped about seeking help because of a fear of ICE discovering her, or at the least, someone reporting her to immigration authorities. She embodied fearfulness and “unbelonging” (Bendixson 2020), and her decision-making corresponded to the operations of structural violence and inequality. Anti-im/migrant policies and a fear of deportation compounded her already arduous situation, and the uncertainty of what could happen if she sought care disintitiled her freedom to access care for a significant period of time.

Nonetheless, when her health problems began to mount, in particular an injury to her spine that left her severely immobilized, Shauna was left with no choice but to seek care. Using her resources and personal network—social capital—she was able to use a friend's ID to access care without sharing her unauthorized status with emergency room providers. However, for Shauna, the anxiety of the moment increased, and her blood pressure began to rise. The providers were left uncertain of the cause as they found no biological reason for it, and potentially, a mismatch of medical records due to Shauna using her friend's ID may have played a role. Regardless, the providers' training to

examine and intervene with the body provided no resolution for Shauna's hypertensive state. While her body held the medical problems she was facing and required intervention, the true issues lay in the structural systems that caused Shauna's anxiety and made it difficult for her to support herself, stay well, and communicate her problems. In other words, the answers to understanding and resolving Shauna's high blood pressure were not in or through her body, but the social structures and systems that were damaging her body, mind, and soul.

From the emergency room and hospital, Shauna was referred to primary care at BMC. First, Shauna saw a female physician. As I outlined in chapter five (trust and communication), the care Shauna received at this point consisted primarily of small gestures of care and social interventions that mitigated day-to-day stressors—gift-cards to buy food and a bag of clothes. As I wrote then, these interventions are significant and help patients build trust with providers. There is a grace to these clinical acts. They alleviate daily stress factors and treat the body in socioecological space, not as solely a biological entity (Andress and Purtill 2020).

However, as I also noted in chapters four and six (structural competence and interprofessional collaborative care), there are additional levels of structural intervention and forms of collaboration that providers can apply to help their im/migrant patients (Mattessich, Bartholomay, and Martin-Rodgers 2017; Neff et al. 2020). To that end, the embodiment of clinical competence for treating im/migrant patients is the result of a combination of skills and knowledge from multiple areas. A provider cannot claim competence if they are an expert on immigration policy and collaborative care, but fails

to effectively communicate and build trust with patients. There are multiple realms of knowing and doing that add up to the status of attaining clinical competence.

Furthermore, Shauna's first provider, while gaining her trust, failed to successfully collaborate and provide genuinely meaningful solutions to her housing insecurity. (Note: Shauna did not inform me why she transferred physicians, whether this was her decision, or whether her original physician left BMC).

In her ensuing encounters with her current primary physician, Shauna shared experiences that are emblematic of what it means for a clinical provider to deliver excellent, high-quality, structurally-informed care to im/migrant patients through each of the three clinical areas I mention in this thesis. First, upon meeting this new provider, Shauna informed me that she was still homeless. This, in itself, signifies that her first provider did not effectively meet her most pressing need, safe and secure housing. As Shauna shared, the constant inability to stay in one place and deal with the dangers and worries associated with street life and deportation began to cause mental health issues. To all these points of struggle, Shauna says that providers and patients must be partners, and below, I share a story Shauna told me that epitomizes the benefits of the partnership she has established with her newest and current doctor.

Shauna: It's a partnership. They [the provider and patient] work together. Yes. So, I'm not gonna blame doctors. Cause I gain mine by opening up. That's how I gained mine. I opened up. And it leads me from one question to another question. And that's how I got my apartment. I'm so happy I'm not homeless. I've been through a lot. People kick me off their couches and stuff like that. And I just went to my...I didn't wanna tell my [new] doctor either. And I eventually went to my doctor. I said, 'I'm homeless.' And he looked at me, and I was like, 'Yes, doctor. I'm homeless.' And he was like, 'Since when?' And I told him, and he said, 'Okay.'

He gave me a whole bunch of applications. He said something like, 'Just fill out these and send them in.' I didn't even send them. And I'm going home one night and two guys rob me. So, I end up moving from where I was...I was walking home from the train station and they rob me. From work I'm coming from. And I had to move from where I live to nowhere [the street].

[After the robbery, behavioral problems mount and Shauna checks into a mental institution].

And that's when my doctor called me in the mental institute. Cause, I was, I couldn't take it no more. The doctor called me...[emotionally] He, he checked on me in the hospital. Can you believe that!? Oh my God! So, I said to him, 'I'm, I'm in the mental institute.' And he was like, 'Since when,' he asked me. And I tell him, and he was like, 'Did you contact the people with the housing?' I said, 'No.' He said, 'Call them now.' I never even thought to call them. And I spoke to a lady, I really don't remember her name, from Quincy housing. And I explained my situation. I said that I was in the mental institute right now. And she told me as soon as I get out the hospital I should come straight to her. And that's how I got my apartment.

I love my doctor! I love him, love him, love him! He finds all solutions for me, and I'm a person with 21 solutions [problems] to solve [laughs]. And he solves all of them. My doc—I feel much more talkative to my doctor than to go to my social worker. That's how much we communicate. Yeah. He helps me. He helps me a lot. Every month when I go in to see him, I get a different connection. It's, it's great to have a relationship with your doctor. It's a really great feeling. Very very great feeling to have, to build a great relationship and let it grow. Let it grow from there. And they [the patient] will be okay. But I love my doctor [laughs]. I love him. He helps me in [emphasizes] SO many ways. I have no family here, and he makes me feel like I have a family. Yeah.

Shauna mentions a critical aspect of communicating with im/migrant patients.

Care can only progress if the patient feels comfortable enough to “open up.” As Shauna says, this is a two-way process; she was only able to receive help from her doctor, and her doctor was only able to provide help, because she communicated. The key, therefore, is that her provider created a clinical space in which Shauna felt she could peacefully share a serious matter of her life—her homelessness. Upon sharing such a detail, rather

than respond with stigma or blame, Shauna's doctor reacted with compassion and problem-solving. This is no different than her previous physician. However, this time, her provider supplied housing—structural—resources and interventions. His job as a doctor is not about solving housing problems, but because housing, or a lack thereof, affects health, he, unlike Shauna's first primary care physician, understood that it is a professional obligation to know about housing issues and develop collaborative interventions that mitigate patients' housing insecurity.

Moreover, he also understands that communication with patients is not bound to the clinic. When Shauna was in dire straits, admitted into a mental institution in the wake of a robbery with nowhere to go upon discharge, he called her. He reached out to check-in and make a plan, and as a result, truly gained Shauna's trust. To her, this was a genuine act of kindness and a symbol of her doctor's sincere concern for her wellbeing—the enactment of modest, graceful gestures of care. But what is more, Shauna's doctor took the structurally informed and collaborative steps to guarantee she finally had a place to live. He knew, as Shauna's primary care provider, that he was one of the only people who could jumpstart finding a substantial solution. Subsequently, through collaborative efforts with a housing resource, he ensured Shauna finally had a place to call home.

As Shauna says, her doctor finds all solutions to her needs. He is always finding new ways to connect with her and ensure he is aware of the happenings in her life. Furthermore, he has made Shauna feel like she has family. For im/migrants, who often experience isolation, loneliness, and a loss of agency, this is extremely relevant. Once a provider gains a patient's trust, they may be the only source of support, and resultantly,

they may need to be willing and able to continue troubleshooting the often difficult matters that makeup life as an im/migrant in the U.S.

Embodied Competence

Effective structurally informed clinical practice emanates from an embodied knowledge—competence—of im/migrant patients’ needs and effective forms of intervention. To an extent, this means providers reflecting on what life may be like in an im/migrant body. *What struggles might I have if I [the provider] were in my im/migrant patient’s body?* Akin to the notion of ‘walking in another person’s shoes,’ the embodied competence for successfully treating im/migrant patients starts with thinking about what life might be like for them, in relation to both their current circumstances and past experiences.

This takes the form, first, of reflection. A straightforward strategy to develop a greater competence for treating im/migrants is through reflexivity and introspection (Ménard and Ratnapalan 2013). *What can I, as a provider do better? What influences how I think about medicine, sickness, health, and healing? What may be affecting the health and lifestyle choices of my im/migrant patients?* Moreover, as Ménard and Ratnapalan (2013, p. 105) remark, reflection does not have to happen alone. “Reflection is often thought to be an individual, personal process; however, recent data suggest that this does not always need to be the case, as small group sessions reflecting on individual and team functioning are also valuable.” Care teams can reflect together, discussing their thoughts in a shared manner for the betterment of patient care. The result, as Ménard and Ratnapalan suggest, is that “self–reflective abilities can be nurtured into habit.” In

reaching and cultivating the objective of embodying the skills for treating im/migrant patients, reflection helps drive habitual knowledge and action.

Second, the embodied competence for treating im/migrant patients flows from the accumulation of knowledge through training, experience, literature, and speaking with patients over time. Competence is not attained overnight, and often, the information and skills required to be a competent provider change as research develops new insights and interventions. Subsequently, one of the greatest assets a provider can hold is devotion to understanding the ever-changing complexities of healthcare and immigration policy. As I mentioned above regarding reflection, the accrual and development of knowledge, skills, and abilities does not have to occur alone. While a provider can take-in and amass a wealth of knowledge and abilities by themselves, such as through reading this thesis, effective and useful clinical prowess comes through the teachings from and observations of others. This is the benefit of medical schools and graduate medical education. Almost always, there are more experienced professionals who share their wisdom and acumen for successful care delivery.

This comes from both didactic trainings within the classroom and clinic, as well through role-modeling (Kenny, Mann, and MacLeod 2003). In my observations of the resident precepting in the General Internal Medicine Immigrant and Refugee Health Clinic, attending physicians emphasized holistic forms of care and inquiry, and the primary means of transmitting the embodied competence—“enskillment” (Ingold 1996)—for treating im/migrant patients flows through recognizing the social needs and stressors of patients and that care is not confined to the body. For example, one resident

returned to discuss a patient with the attending physician, heavily noting the physiological state of the patient relative to the diagnoses. The attending, in response, simply asked, “But, how is the patient doing?” In other words, *beyond the physiological functioning of the body, what is the patient’s quality of life, and what is making the patient’s life easier and harder?* The attending was pushing the resident to reconsider what successful care for im/migrants entails, accentuating that competence in this realm of medicine is more than the management of disease.

Furthermore, developing and maintaining the embodied competence for treating im/migrant patients requires a form of “body pedagogics” (Kelly et al. 2019)—bringing enhanced attention to healthcare providers’ “sense of embodiment” rather than clinical cognition. First, as Kelly and colleagues note, this involves providers recognizing the institutional influence of biomedicine on their body. Within the institution of medicine, there are standards, practices, and rituals that mediate learning and professional development. In one way or another, these experiences and forms of medical enculturation affect embodied being and the delivery of care.

The institutional means of body pedagogics are reflected in the situational structures and conditions that teach students ‘ways of knowing’ that draw on and hone the use of multiple sensoria. However, institutional means can also lead learners to develop sensibilities that are irrelevant to patient care and may even be harmful: for example, by focusing on listening to a patient’s heart, a learner may neglect to listen to what the patient is saying, or, in their focus on the use of electronic medical records during consultations, practitioners have been shown to make less use of non-verbal communication (Kelly et al. 2019, p. 969 and 970).

The point is recognizing how biomedicine structures one’s body, as a healthcare provider, to behave and practice medicine. Regarding the treatment of im/migrant

patients, this may mean considering how one's body language or wearing of a white coat influences the medical encounter. In terms of training, it means developing providers with an innate awareness of how institutions shape not only their own "bodily practices" (Kelly et al. 2019), but that of patients. *How have social structures and the institutions of biomedicine affected how I use and think about my own body? How do the social structures and institutions in the U.S. and abroad affect the lived experiences and embodiment of im/migrant patients?*

The second concept Kelly et al. (2019) mention is embodied "enskillment," a term first introduced by Ingold (1996) and further discussed by Harris (2016), which refers to how skills become embodied. Here, providers, both as educators and learners, think about their own processes of intellectual and professional development. *How did I come to learn and know something? How do other providers influence my learning?* Returning to Bourdieu's theory of *habitus*, the main objective is considering how the culture of biomedicine shapes embodiment and clinical habits.

Last, Kelly et al. (2019) note embodied outcomes, "changes in bodily capabilities that occur as a consequence of learning" (973). New skills become "bodily appropriated," simplifying clinical actions and decision-making over time as one becomes exposed to new sources of enlightenment. Providers considering the manners in which their mind has taken in information and altered the use of their body is significant. *How do my skills and knowledge affect the delivery of care? How does my body reflect the skills and knowledge I have attained?*

As Kelly et al. (2019, p. 973) write, “Becoming an expert [in medicine] involves developing bodily expertise as well as cognitive capacity; physicians’ bodies, not just their minds, are honed and crafted in order to enact their expertise.” Cognition is hardly the chief principle of clinical competence. Expert status stems from understanding how one’s mind, through learning, influences one’s body in relation to other bodies. In terms of care for im/migrants, it means providers recognizing the diverse array of sociocultural and structural forces that affect the im/migrant body and sense of selfhood. Providers can then connect their intellectual capacities with bodily intentionality, delivering care that accounts for and addresses the results of structural violence and vulnerability in im/migrant lives.

Returning to my observations of resident precepting in the IRHC, competency development emphasizes seeing the patient’s body in socioecological space, shifting the “medical gaze” (Foucault 1973) from solely the operations of body systems to the structural factors that intersect im/migrant lives. A recognition that true healing, effective care, and the embodiment of clinical competence arises from understanding and engaging with the larger forces at play that affect im/migrant health, including the U.S. health system.

Im/migrant Embodiment

Aspects of im/migrant embodiment are considerably structurally informed. In terms of structural violence and the specific policies, social structures, and belief systems targeted at im/migrants, sociocultural worlds across borders influence im/migrant embodiment in unique ways. For example, embodiment, whether one is an im/migrant or

not, is affected by upbringing and the social and cultural stimuli that form one beliefs, values, ideations, goals, opinions, practices, actions, or otherwise. These experiences and valuations, for better or worse, influence how we exist in our body and how we experience and perceive the world (Carel 2016; Merleau-Ponty 1962). They influence what we consider good vs. bad, righteous vs. unjustifiable, worthy vs. unworthy, etc., and further, they influence how we interact with other people.

Returning to im/migrants, existing in one's own body—an im/migrant body—is especially complex in relation to governance after movement across international borders. First, relative to anti-im/migrant policies and nativism in the U.S., im/migrants may embody “unbelonging” (Bendixsen 2020), manifesting bodily intentionality that avoids risk. Im/migrants may feel targeted, and as result, they may perceive their ‘being-in-the-world’ as an endangerment—the im/migrant identity as connected to forces of discrimination and deportation. An “embodiment of political order” (Fassin and D’Halluin 2005).

Further, in terms of social belonging and economics, im/migrants need to quickly adjust their bodies and body movements to the capitalist system ingrained in the U.S. As Brown (2017, p. 1) notes, im/migrants

must adapt and retrain their bodies, often under great pressure, to meet the demands of American social institutions [...] Immigrants who struggle to execute the host society's normative bodily movements (1) interpret their bodily challenges as evidence of their outsider identity, (2) struggle to acquire the material resources necessary to achieve more traditionally studied forms of economic incorporation, and (3) face limitations in their ability to maintain transnational networks even as those networks play an increasingly important social role in the face of their blocked mobility.

To phrase this differently, when im/migrants move to the U.S., the ways they think about their body and use their body affect settlement. If one cannot adjust how to use their body for one's benefit, whether through interacting with U.S. institutions, forming social relationships, working, or otherwise, life in the U.S. can quickly become a danger to wellbeing. Recognizable and common tasks such as punching a time card, driving a car, taking a test, ordering food, going to the ATM, picking up a prescription, and much more may be unfamiliar to im/migrants and unusual in their originating sociocultural environments. In one way or another, the adaptation of how to use one's body across transnational localities refers to *bodily incorporation*, or "the struggle to resocialize one's body to perform the movements required by host society institutions" (Brown 2017, p. 2). Relative to how im/migrant bodies may have been socialized prior to movement across international borders, they may have alternative perceptions of how to use one's body in new social and economic contexts.

Adding on, from a sociopolitical lens, the body could also be considered the root of an im/migrant's worth. For refugees and asylum seekers, their body holds the key to their entry across U.S. borders relative to the vulnerability and trauma their bodies and minds may have undergone.

The body has always been a privileged site on which to demonstrate the evidence of power. But for immigrants, the poor, and, more generally, the dominated—all of whom have to prove their eligibility to certain social rights—it has also become the place that displays the evidence of truth [...] The refugee's body, thus, becomes the place of an inscription, the meaning of which relates to a double temporality: an inscription of power, through the persecution they suffered in their home country, and an inscription of truth, insofar as it bears witness to it for the institutions of their host country (Fassin and D'Halluin 2005, p. 597 & 598).

Subsequently, and seemingly in opposition to embodiments of unbelonging, the im/migrant's body is the reason they are deemed worthy enough into the U.S. The etchings of violence and condemnation appear on and/or in the body, establishing proof of one's languishing past. However, as I previously noted, such worthiness ceases once admitted into U.S. borders. Operations of discrimination, xenophobia, and economic inequality trounce perceptions of 'being-in-a-body' of value and worthiness.

Limitations

There are a number of limitations of this study, which to reiterate, was part of larger project at BMC's Im/migrant Refugee Health Center (IRHC). First, I only collected data from patients who speak English. Considering the negative affects limited English proficiency (LEP) has on socioeconomic status and abilities to access and receive high-quality health care, there is critical information I may have missed excluding non-English speakers. This decision was not made lightly and was a matter of not having the funding to cover the cost of linguistic interpreters. Furthermore, I did not stratify for gender, age, im/migrant typology, or otherwise. If a patient was not born in the fifty U.S. states, was eighteen or older, spoke English, and had received care from BMC in the last year (which is also a limitation), I allowed them into the study. Again, this decision was made with respect to funding, as the IRHC did not have the monetary or time flexibility to pick and choose specific participants.

Moreover, the transition from in-person interviewing to phone-call interviewing following COVID-19 likely affected the quality of the data. The most informative and interesting interviews, I thought, came from the ones I conducted in person where I got to

see the patient face-to-face and develop a relationship, if even for a short time. This is why I mentioned the participants Shauna and Margaret so frequently. Unlike the patients with whom I spoke over the phone, I was able to connect with them more directly. Had I been able to conduct all interviews in person, I strongly believe the data would have been richer across the board.

To that end, COVID-19 and all its safety measures, while necessary, took a toll on me as well. The mental fatigue of remote everything, feeling trapped in my apartment, and dealing with the overall uncertainty the pandemic brought made completing this thesis more difficult than I anticipated. Without discounting my own work, I suspect that this thesis would have been better if COVID-19 had not happened. COVID-19 itself was a limitation. Furthermore, social distancing, along with what was essentially a shutdown of the city of Boston, made participant observation a troublesome task. This, in many ways, limited data collection and the types of data I could gather and incorporate into my thesis.

Key Themes of This Thesis

Structural Competence

All other realms of im/migrant care stem from structural competence. From the push-pull factors of migrating, to the effects of neoliberal economics and xenophobic policies, to the operations of bureaucratic disentanglement, the reasons for im/migrant sickness, ailment, and distress are often brought on by larger structural forces.

It is paramount that clinics and providers operationalize screeners to assess im/migrant patients' structural vulnerability. One of the most efficient and effective

manners for such assessment is through social determinants of health (SDH) screeners, and at BMC specifically, the THRIVE screener. Providers can either conduct these questionnaires with patients verbally, or patients can answer themselves on paper or a tablet. SDH screening, as a result, not only leads to better health outcomes, but also reduces healthcare costs.

Furthermore, one of the most optimal ways for a provider to understand how structural violence has affected their im/migrant patients is to gather the patient's migration narrative. Stories are powerful forms of communication for im/migrants, piecing together the past, present, and future relative to their movements across international borders. Narrative contextualizes the life of the im/migrant patient in contrast to the presence of social structures, detailing what and who matters to them, what they have lost, and what they hope to one day regain and achieve. In sum, effective trust-building, communication, and collaboration—the other domains of competency I discuss in this thesis—only arise once a provider understands the structural, cultural, and political factors that affect their im/migrant patients' lives.

Trust and Communication

Because of the common loss of personal agency at the hands of state actors im/migrants undergo—especially forced migrants—one of the primary goals of providers is to return agency to these patients. This consists of assuming trauma and consistently asking for consent. If a provider does not assume trauma nor ask for permission from the patient prior to questioning or physical examination, even the smallest trigger may result

in retraumatization. That said, providers should not assume anything else about the patient, and care should always strive to be patient-centered and patient-involved.

Secondly, negotiation—communication between patient and provider across explanatory models of illness—is of great significance when treating im/migrant patients who often hold knowledge of and adhere to forms of complementary and alternative medicine (CAM). For providers, the utmost concern is that CAM practices do not harm the patient, and the primary goal when there is discrepancy with patients is working together to determine mutually agreed upon next-steps that circumvents the paternalism of biomedicine.

Last, small gestures of kindness that tangibly mitigate daily stressors stick out to patients and leave an impression that the provider cares about them and listens to the small details they share. A coat. A pair of shoes. A gift card. A phone call to check-in. These modest, yet meaningful actions speak volumes to im/migrant patients. They help combat the daily stressors of lived reality and build relationships imbued with trust and security.

Interprofessional Collaborative Care

The provider's most important collaborator is the patient. The patient is the holder of pains, ills, and experiences of structural violence, and as such, care begins and ends with the patient. They are the expert in their own health and sickness, and including them in care, particularly for forced migrants, can be liberating. Additionally, patients can often be effective collaborators for other patients. They can work together, talk, and help each other heal through mutual storytelling.

Furthermore, care for im/migrants requires a network of different providers. Due to immigration law related needs, trust issues, behavioral health problems, and the unique cultural backgrounds of im/migrant patients, collaborative efforts with, but not limited to, immigration attorneys, legal navigators, community health workers, housing specialists, religious leaders, CAM providers, and social-workers and counselors can prove advantageous. Furthermore, important collaborators can also include family members and friends who may be intimately involved with the patient's care decision-making.

The most significant, underpinning aspect of collaboration is professional humility: providers acknowledging that they do not have all the answers and need to work with others to adequately solve the problems im/migrant patients bring to them. Whether it is persistent, unresolved gastric distress that requires a gastroenterologist, chronic homelessness that requires a housing specialist, an immigration situation that requires an attorney, or a spiritual crisis that requires an Imam, it is essential there are other professionals that providers have in their network to call upon for help or referral.

Next Steps

Next steps for this research primarily includes further exploring what embodiment looks like in the clinical realm of im/migrant and refugee health. This thesis barely scratches the surface of what it means to hold and embody the competence for treating im/migrant and refugee patients. More work need to be done to determine how the specific forms of knowledge and skill needed to deliver high-quality care to this patient population is transferred from attending to resident physician. In addition, it would also be beneficial to assess the learning and clinical practice of residents as they go through

training, providing a longitudinal opportunity to examine the development of embodied competence in im/migrant and refugee health over time.

Adding on, it would also be advantageous to further and continually examine embodiment in im/migrant patients, the ones who receive the care. Immigration policy is always changing, as well as the global phenomena and events that push people across international borders. How ‘being in an im/migrant body’ alters across space and time is a critical dimension of care in this clinical specialty. Without understanding what im/migrant bodies go through, what they are subjected to, and why, providers cannot deliver truly meaningful and competent care.

Future Research

As I noted in the introduction and methods chapter, future research also includes synthesizing the data of the core competencies study to formulate specific ACGME core competencies recommendations for im/migrant and refugee health. The purpose for this is to establish a clinical fellowship and continuing medical education course for this clinical specialty at BMC. To do so, this thesis can provide a foundational stepping-stone, where the literature, stories, and data analysis I present can be used to inform the development of specific ACGME competencies in im/migrant and refugee health.

Concluding Remarks on Remaining Questions

Do immigrants have need a dedicated space to get care they need? What about in clinics that are not a dedicated health home for im/migrant and refugee patients?

Relative to the needs and background of the patient, a dedicated space for im/migrants can prove tremendously helpful, but it is not a necessity across clinical

spaces. For example, new refugee arrivals require a refugee health examination at an approved facility. Here, there are specialized providers who have the clinical training and knowledge of the immigration system to properly examine and treat forced migrants. As I have noted, these are patients who may embody a fear governmental institutions, such as healthcare, and have histories of traumatic experience that alter their embodied states and emotions. This entails specialized forms of care, both in terms of recognizing how the im/migration journey can result in bodily and emotional harm and how to handle the effects of trauma. Moreover, care from specialty medical homes for im/migrant patients likely have a better understanding how structural forces and experiences affect the embodiment of im/migrants and why they make certain decisions, such as avoiding care or declining services.

Furthermore, in terms of structural violence and the specific policies that target im/migrants, specialized clinics dedicated to im/migrant care are likely more informed and have stronger collaborative interventions and resources available for housing, job-training, ESL classes, and food and clothing donations compared to regular clinics. To that end, specialized im/migrant health clinics often have better tools to help address the patient's body in space. They have a greater capacity to help attend to the patient's social stressors, teach them how to navigate the U.S. health system, and assist them with building capital for managing their own health over time. However, as a result, patients who once needed the help of a comprehensive health center for im/migrants can 'graduate' to normal primary care. Over time, providers can help im/migrant patients

expand their knowledge capital, learning how to use their body in effective ways to both access care and participate in U.S. society.

Moreover, when a patient has an immigration related concern, specialized providers and clinics with immigration legal resources significantly benefit health outcomes. Not only do these services address the immigration issue(s) through legal avenues, but they also alleviate the contributing stress of such dilemmas. These care provisions directly alter the embodied states of im/migrants, giving them a tangible legal resource devoted to protecting and/or improving their status on U.S. soil.

All this said, im/migrants do not have to seek care at specialized clinics to receive high-quality care. Sure, it helps. But, any provider in any clinical setting is capable of understanding the structural issues im/migrants face and the specifics of care delivery for this patient population. The key is recognizing when the health and/or social issues are too complex to handle and go beyond one's expertise. This, to a certain extent, refers to recognizing one's bodily limitations and what one can do with their mind and body to help the patient. Like referring a patient to a specialist for the diagnosis and management of kidney or liver dysfunction, one can call upon the help of providers in dedicated im/migrant health clinics.

What does it mean that we are requiring providers to have specialized knowledge—should all providers be able to provide this kind of care? What is it reasonable/realistic to expect? How do we support it?

Specializing in im/migrant and refugee health and embodying the competence to treat im/migrants are two separate qualities. While the former is to dedicate one's career

in healthcare to im/migrants and hold focused, in-depth knowledge of the subject for sharing with others, the latter is to genuinely know how to treat this patient population from embodied traits and skills. Specialized providers in im/migrant health often have the competence for treating this patient population, but one can also be a healthcare provider and attain the competence for treating im/migrants without specializing in this field. A reasonable expectation is that im/migrant health specialists are called upon for complex situations and patients that required certain types of embodied skills and knowledge. Again, this comes back to providers recognizing how they exist in their own body and being aware of their limitations both in terms of knowledge and clinical action. Relative to treating im/migrant patients, it means acknowledging that specialized providers with in-depth expertise and know-how likely have a better grasp of what life is like being in an im/migrant body within the U.S. social, cultural, and economic landscape.

For example, an im/migrant family dealing with intergenerational conflict might require specialized care from a provider who understands the nuances of navigating these scenarios. Or, an asylum seeker who has arrived in the U.S. alone, subsequently dealing with isolation, family separation, unemployment, housing insecurity, and emotional distress might necessitate the help of a comprehensive, dedicated health center for im/migrants. The objective, in supporting the dichotomy between services at specialized im/migrant and refugee clinics and normal health clinics, is developing and nurturing collaborative relationships across the community. This entails ensuring small, community clinics and organizations are aware of specialized im/migrant services and can refer when needed. Moreover, when im/migrant patients progress to the point they no longer require

the in-depth care of a dedicated im/migrant health clinic, collaborative partnerships with smaller clinics ensure warm-handoffs and care coordination as needed.

Are there negative consequences to having this kind of dedicated/disciplinary space?

While there are certainly benefits to having dedicated clinics, providers, and clinical programs in im/migrant health, there are also negatives. The trade-off is whether specific clinical efforts for distinct patient populations results in more stigma. The question under consideration, then, is whether or not the provision of a certain type of care for certain people results in more harm to wellbeing than the benefits of care itself. As numerous authors have determined in the realms of mental health care (Knaak, Mantler, and Szeto 2017), substance-abuse treatment (Hammarlund et al. 2018), HIV care (Anderson 2009), and LGBTQ+ medicine (Whitehead, Shaver, and Stephenson 2016), stigma related to these identities and realms of medicine affects health-seeking and results in the underutilization of healthcare services. Simply, seeking care at these specialized clinics can be stigmatizing, and developing the notion that distinct patient populations require certain types of care may be harmful. The driving force is difference, imputing that the provision of care for certain patient populations reinforces stigma. Moreover, distinct clinics for specific patient populations may fortify the notion that human bodies are different based on social identity. This can cause additional harm to already marginalized groups, stigmatizing the bodies and identities they inhabit, altering how they use their body and pushing them ‘be-in-the-world’ as The Other who requires certain forms of care to treat their body.

But, how does this differ from a geriatrician specializing in treating the elderly, or a gastroenterologist specializing in IBS and Crohn's disease? Do they not have specialized knowledge for treating certain patient populations? The key is realizing why a domain of medicine is considered stigmatizing in the social world and how stigma can be combated. Differences between patient populations is not the problem, it is that certain diseases and identities are stigmatizing and that care in terms of socially informed identity can bolster embodied unbelonging. Consequently, delivering care in the context of stigma may reinforce the specifics for why specialized care is required, strengthening notions of human difference. That said, this should not take away from the fact that dedicated clinics for marginalized identities and stigmatizing diseases, such as substance abuse dependency, HIV, or im/migrant status help patients every day. It would be a disservice and a waste of energy to say the negatives outweigh the positives and remove such clinics. The objective, rather, concerns why these clinics and their patient populations are stigmatized and ameliorating the societal roots of these perspectives in an effort to help patients become confident in the bodies and identities they inhabit.

In Conclusion:

A provider who embodies the competence for treating im/migrants, first and foremost, understands the structural dynamics at play which affect im/migrant health. The push-pull factors that result in im/migration are structurally rooted, and therefore, at the core of every im/migrant's journey are the structural forces that underpin the need for human movement across borders. Persecution. War. Lack of jobs. Pollution. Limited socioeconomic opportunity. Energy projects. Land development. Deforestation. These

reasons for im/migrating, and more, are all in one way or another related to structural forces and operations.

To add, these forces, in infinite ways, affect the embodiment of im/migrants, influencing how they live in and think of their own body. They may begin to develop new feelings, emotions, and thoughts—derived from migration related experiences—that change how one exists in their body. A dynamic and ever evolving metamorphosis that demonstrates im/migrant being in a world relative to more powerful forces. Loss. Death. Isolation. Terror. Uncertainty. Apprehension. These feelings, emotions, and affectivities relay perceptions of lived reality, informing how one lives in the body they inhabit—how one behaves, expresses them self, and interacts with the world.

Moreover, clinical competence also includes knowledge of and engagement with the structural forces of health disparity and inequality in the United States. Once arriving in the U.S., the forces of structural violence hardly cease. Limited access to healthcare services. Lack of English as a second language (ESL) classes in schools. Racist and xenophobic belief systems (naturalized forms of persecution). Disordered capitalism and income inequality. Bureaucratic disenfranchisement. Unemployment. The list goes on and on. As such, there is a critical need for providers to understand the structural pressures im/migrants face and how they might be mitigated at different levels of intervention. A pair of shoes. A coat. Partnerships with local housing authorities. Writing letters to bureaucrats. Research. There are many ways providers can make a meaningful impact in their im/migrant patients' lives, both through clinical practice and structural intervention. To that end, clinical competence also refers to understanding how these social

interventions change how im/migrants live in their body, and how helping the body in space or assisting patients with how to use their body in the social, cultural, and economic environment of the U.S. can have beneficial outcomes.

Overall, a competent clinician is humble, compassionate, dedicated, and aware of structural operations, and they understand the lived experience of being in an im/migrant body. They strive to deliver a form of holistic care that recognizes the humanity and diversity of intervention such patients require. The roads im/migrants have traveled, the experiences they have gone through, and the stories they have to tell are unlike any other patient population.

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CURRICULUM VITAE

