Ketamine for Mental health in Pediatric Emergency Medicine Transcript

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Podcast Introduction and Guest Welcome

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Welcome to the To Curious in Me podcast. I'm Dr. Ali Ahmed. And I'm Dr. Surya Ravan. In this podcast, we are asking the unasked questions. We're physicians applying the lens of narrative medicine, exploring integrative practices and psychedelic treatment and health.

Together with our guests, We weave new learnings from stories, expertise and the sciences. With the wisdom from holistic, alternative and these conventional medicines, we are here to challenge the status quo.

We're curious about the connectivity and complexity between diverse fields of knowledge as a relief to consciousness, chronic illness, mental health, resilience and beyond.

Learning more about art and science of healing or listening to stories of extraordinary healing. You're in the right place. Let's dive in. Welcome to To Curious MD podcast.

I'm Dr. Alia Ahmed. Together with Dr Saraya Rehman, we are asking the unasked questions. We are physicians applying the lens of narrative medicine, exploring integrative practices and psychedelic treatment in healthcare.

Together with our guests as we speak to Tanya today, we are weaving new learnings from stories, expertise, and the sciences. And with the wisdom from holistic alternative and conventional medicine, We are here to challenge the status quo.

So welcome. We are curious to learn more about what you do, Tanya. And that's right. Let's dive in. Thank you so much for being here. Tania, you're just such a great friend and we've just clicked so perfectly.

All three of us are pediatricians, so our hearts really align almost from the moment of of meeting and so let me give a little introduction on Dr. Tanya Vaingorton.

She is a pediatric emergency medicine physician in San Diego at Rady Children's Hospital.

Mental Health Crisis in Youth and the ED

she completed her residency in pediatrics and fellowship in pediatric Emergency Medicine and she's also the wellness director for the emergency room there.

She is conducting research on ketamine for depression and suicidal ideation in adolescents. And so this is a topic that we're going to be delving into the healthcare system from practitioners who know what our patients and their families are going through.

This is just such a treat to talking to you today, Tanya. Thank you for being here. Yeah, thank you guys so much for having me. I'm really excited to discuss these topics and reconnect with both of you.

Yeah. You know, ketamine, mental health, the crisis that we're seeing in the hospitals and the emergency room is a real thing, especially in a young adult and adolescent.

More and more of these, you know access that patients are obtaining through the sometimes can be preventable, sometimes it can addressed in a different setting and I can't even imagine what that feels like for you in the emergency room as the crisis continues to be an issue even post-COVID as every scene of numbers rise and rise, and continue to rise more and more.

So what do you feel as we open up to this conversation comes to mind when you think about mental health, the crisis in the emergency room, and your work in ketamine treatments as well, in your research work and ketamines?

What have we learned? Yeah, so we're definitely in a mental health crisis, both for teens and adults, but especially for youth in the United States, and that's really worsened since the pandemic.

There are surveys showing that high school students, you know, about a quarter of them have experienced depression or even had suicidal thoughts before, really a concerning time and our mental health crisis really started worsening.

I started noticing it a lot more during the pandemic. We really had an increase in visits for suicidal ideation to the emergency department for suicide attempts, fell harm, it really skyrocketed.

Whereas, for example, Even during my training 10 years ago, I hardly ever saw these patients. Yeah, we've been experiencing a tremendous mental health crisis, especially in our youth.

Really started noticing it during the pandemic. So for example, when I was training ten years, ago I, hardly, ever, saw any depressed or suicidal patients in the emergency department.

But around the time of the, pandemic we started seeing them every single day, a huge increase in visits for, depression, suicidal ideation, suicide attempts, self-harm.

It was shocking and very upsetting, and these teens really had nowhere to go because of the pandemic and difficulties with accessing health care, often fear of accessing healthcare due to health concerns.

They couldn't get into a therapist. Sometimes the waits for psychiatrists were six to 12 months, so a lot of them were presenting to the emergency department.

And our role as the ER doctors would be to perform a medical evaluation, make sure there was no medical reason going on for their symptoms, and otherwise determine if they need to be hospitalized or not.

But the problem with that, if there were in a mental health crisis and they needed to hospitalized, was again that they would have nowhere to go. There was often long waits to get into an inpatient psych facility.

We have a huge shortage of all adults, all psychiatric beds, but especially pediatric. And so sometimes they would be spending days in the emergency department, really just in crisis and not receiving the care that they need.

It was around that time during the pandemic that I had learning about catamine. I actually had attended a virtual conference where there were different speakers.

They were physicians and they were talking about kind of non-traditional clinical roles and side gigs and projects they're involved in. And I heard an interview with ER physician that had a ketamine clinic and he was discussing treating depression with ketamines.

I thought, oh, that's really fascinating because we use ketamin all the time for procedural sedation and I wasn't too familiar with the mental health uses of it.

And I reached out to him to talk to them more and I started reading more about it, researching the literature, connecting with others in the field, including both of you.

I thought, wow, there's really something potential here that there is a large body of evidence showing that ketamine can be a rapid acting antidepressant.

Whereas our traditional antidepressants can take weeks to start working, ketamine can work even within hours to reduce suicidal thoughts. And so that's how we came up with the idea for this clinical trial to give ketamines to suicidal teens in the emergency department.

The goal of that was to try to meet them where they're at in crisis to help them feel better while they are awaiting that definitive care with inpatient placement.

I love that. I loved that because as pediatricians who work on the inside of the hospital, as well as the emergency room and the outpatient, we know that this crisis is everywhere.

It's happening in big cities, small towns. Its happening on both coasts. its happening everywhere because we're experiencing it at many levels of this healthcare system.

And I Love that what you did was look for, you found a potential solution.

Launching the Ketamine Research Study

And you spent, you know, your energy to actually see if that solution could work in your own environment. Can you tell us a little bit about that process and what that took for you to get people on board to say, hey, maybe we could use this?

And what you learned from that experience of actually trying to do research on ketamine for mental health disorders in the emergency room. Yeah, it was a very long process from the idea to when we actually started enrolling patients took about a year.

I first pitched the ideas to one of our psychiatrists to see if she wanted to collaborate and she was very interested. But then we had to get approvals from a lot of different groups in the hospital.

Again, everyone was familiar with ketamine for procedural sedation, but that dosing is you know, sometimes 10 times higher than what would be used for depression and suicidal ideation.

So, we had to create a new policy to say, you, know this is not a sedation, this not requiring as much monitoring, and this was not as invasive, but we have to meet with our hospitals groups, our ICU, or anesthesia groups.

because typically, again, these medications had only been given by anesthesia, for example, or just in the emergency department. So we were really trying to show a new protocol, a different way of using this medicine and getting everyone on board, which eventually everyone was, but it took quite a bit of time to get all the protocols ironed out, and it was really out of the box.

compared to what everyone is used to. I think it's funny because yeah, in medicine sometimes things are so rigid. Everyone has their protocols and their pathways and this group does this, this groups does that.

And sometimes you have to push people a little bit to try something different. It very much sounds like you got the idea or connected with the ideas, knowing and having a relationship with ketamine as a provider, seeing it and, you know, became acknowledged this different approach, I guess, and different use in the emergency room setting.

But it almost sounded like something sparked you to really go through this journey, right, where you felt compelled to go to the board, go the hospital, meet with all the task groups and organize all these things to do the work that you're very much something there.

What do you feel was that spark or that that motivation or that drive that really helped you or facilitated this process for you and what was that like for ya?

Yeah, I think it was just seeing that what we are doing is not working, the status quo is now working and connecting with providers in the field who were using canamine in this way and seeing these huge results and doing other research on psychedelics and existing data and how much evidence there was growing and growing, and how passionate everyone was about the field really led me to push like, hey, we should try this here.

Yeah. I imagine also that you're witnessing these teens, adolescents, young adults who are really in crisis mode. I mean, if to seek the care and to be in that state where there's no other option and almost, you know, knowing that there is delay in care in getting to the psychiatrist or the level of care that they need.

As a physician working with each person in the emergency room, how would you describe that experience to the audience or to public? And we know we have a mixed type of audience too.

So we had providers, we people who are just curious about this work in ketamine and this in healthcare. What was that like as a provider working hand in hand with some of these patients who were really in a critical state?

Yeah, I mean, it's challenging. It brings up the concept of, you know, in health care, we talk about like moral injury when you want to give the patient, what care the patients need and what they deserve, but you don't have the resources to offer them what the need.

And I think that can be, you know, really challenging. A lot of these kids come from trauma or kind of dysfunctional households, and they need someone to really spend a lot time with them, to listen to them.

Have a trauma-informed approach. You know really hear them out. And that's challenging when we're also juggling, I have 20 other patients I'm seeing I want to sit and talk to, but I am also trying to deal with these other sick patients and resuscitations.

everything at the same time and our social workers are there to help with that as well. But they're also seeing maybe 10 other suicidal kids and they are running around.

So the system is just so overburdened and yeah, it can be challenging.

Challenges of Caring for Suicidal Teens

I know one particular situation that has been really distressing for me before is we've had a huge rise also kind of since the pandemic in like aggressive patients who are combative.

And again, they're in mental health crisis and you're getting pressure from the staff to put them in restraints because they are trying to attack the stuff and it feels almost like unethical.

I don't want to have this child be in restraint. They're already, again they've been traumatized. Some of them maybe have been abused. But at the same time, I have to protect my staff.

I don't want my stuff to get, you know, punched or injured. And so it creates this, this real like internal conflict of, yeah, how to manage, to help the patients, How to keep yourself safe and your staff safe.

So yeah. It can be a really challenging population to care for because they, they just need so much. Yeah. I feel so much for that. It truly is a crisis, and the emergency room is where the crisis is finding itself.

There's a pinch point there. A place in the system at which most of these kids who are in crisis and their families will end up. What do you see as the potential of ketamine in these kinds of cases?

You're standing there, you can use ketamin for the one patient in Bay A, let's say for example, who's got a femur

fracture, no problem. You've got a protocol, your nurses know what to do.

We know how much to give, we know we'll recover it. And you've a similar age patient right in the bay next door. You know, and you have learned and read that, oh, ketamine could also help this patient.

But I can't give it, you know, it's just, I could just imagine you standing in that little existential space, right, of the absurdity of that and seeing the potential of it.

So maybe, and I think that this is a conversation that's really near and dear to all our hearts because, when we first learn about the potentially of something like ketamine for the acute crisis of a mental health disorder.

First of all, maybe that's the first time we heard about it. I also, in all my years of practice, hadn't heard of this use of it, and so can you tell me a little bit about how you can see this medicine helping these kids and have you seen cases such as what you described start to be de-escalated or at least be helped by this access to ketamine?

as you've done like through your research study? Yeah, yeah, so we had several patients that did have reduction in their suicidal thoughts and did report feeling much better even within one hour, some within three hours after the medication and others did not, you know, and I think it's important to explore like how can we optimize.

figure out the correct dose, the route, and then also how can we optimize the set and setting in the emergency department because that's one concept that comes up a lot in psychedelic world and psychedelics literature is that the mindset and the kind of physical setting and environment can impact the experience.

So in my ideal world, there would be a nice meditation room in a corner of the ED somewhere where They could go, you know, get their ketamine and it could be quiet and relaxing and they could, come out feeling a little bit better.

I think it's challenging for us sometimes when it, especially all our psych patients are in one hallway and you can't control. We couldn't, we would enroll patients.

when the research staff was there, we couldn't control if someone next door is screaming or, you know, something stressful. There's an emergency at that time or what is going on.

So I think we do need to kind of explore more creative ways to create a little bit of that set and setting, even though it's in the emergency department.

And I actually see even with the procedures like broken bones, Some of our nurses are really good. Like when the patient is waking up, they'll have all the lights off.

They're, you know, talking to them in a quiet voice, maybe playing some music. So there's definitely some staff that are kind of more in tune with what's needed than others.

But that's why I think definitely more education about this is needed. Yeah. Because even though when I was doing my ER training and I learning how to do sedation, no one really talked about those aspect either.

And they kind just mentioned, oh, it could be a side effect. It could get agitated. Yeah, if they're not counseled what to expect or know that they are going to be dissociated, yeah, they probably would get agitated.

Well, in my own work with ketamine for procedures in the hospital, one of the things that I observed, of course, was patients having kind of visuals where they were talking through those visuals or they would report.

a sense of calm or ease. And even while suturing or dressing or even burn dressing, they would respond without fear.

Ketamineu2019s Rapid Effects and ED Set Setting

They would talk. There was definitely a conversation I've had with patients on ketamine. So when I learned about ketamines, just like you see me, the same thing was, oh, that's neat.

Now it makes sense why there was that ease of working with patients. I even had one patient who was completely catatonic, came in with complete catatonia, and we were doing a workup for possible, you know, CSF infections, so we had to do a lumbar puncture.

He was a very large-sized teen, but we couldn't get him sedated enough and gave another surround of ketamine. And the next day we did our procedure and patient rested.

Next day, we go in and round. And this patient was completely out of his catatonia. At the time, I was like, oh, this is neat. Oh, great. You know, finally had broken through the catotonic state.

Little did I know that that was possibly the effect of ketamine because a few days later, patient returned back into the catatonic state and we never were able to treat it the same way.

So, but there was hindsight and serendipity and this is how things are discovered in medicine. A lot of things when we look back and think back What are the lessons learned?

And I've had even anesthesiologists describe the use with other anesthetics that patients describe their dreams while they had surgery and how that dream was very helpful to them in their trauma that they've have in life or even for the procedure itself.

They've come in, as well as patients who have reported having ketamine on the ambulance trip, you know, on their way to the hospital. And they report, well, they didn't feel traumatized by the effect of that trauma because of the ketamine.

They were able to even, have a very less emotionally reactive response to a significant traumatic event. And I had one patient who told me this is because of ketamine.

So I mean, there's a lot of discovery in science and medicine that we continue to engage in. What are the lessons you feel you learned through your research work or are learning about, you know, mental health approaches in the emergency room outside of even ketamines?

What other ways do you think? Yeah, I think that, again, we have to be creative and we need to meet the patients where they're at and see what we can offer them when they are presenting for care.

So yeah, in an ideal world, it would be nice for a patient to get in immediately with a therapist and psychiatrist and get whatever medications and treatments they need, but that's not the reality.

And so really exploring, like, what can we offer them when they're present. And I think just this research is really needed or still, you know, there's a lot more literature on ketamine in adults, but the pediatric literature is lacking.

There's much less studies and so funding is needed, support is need. So that's why I've been happy to share, these protocols with other institutions have reached out wanting to do similar studies.

I it's important for the scientific community to really elaborate and pursue this because I think there's definitely a lot of potential. Yeah, going to that, I was really interested in hearing about like just on the health systems level, right?

Like when you talk about just the waiting for placement and the escalation of care, And the fact that we just don't have enough beds, inpatient beds for some of these sickest kids, the potential of ketamine then kind of relief that bottleneck effect, right?

Can you describe some that, like the reality of that? If let's say you have a patient and you're waiting for three days, and you don't get a bed, do you think that's a time when you would encourage EDR physicians like yourself to talk

to their staff and to tell their supervisors to say, hey, what if we could de-escalate the situation right now?

and maybe send them to a different part of the healthcare system. Have you seen some of that happen or the potential for that? Yeah, so ketamine can work within hours.

And so I think it would be really ideal to use in that crisis mode. If a patient got it and did feel better within an hour or within one day and could potentially go home, and follow up with their therapist or psychiatrist that could definitely, you know, shorten their ER length of stay.

It could maybe prevent hospitalization, saving large amounts of, healthcare dollars, time. All of that, again, I can kind of creative models are needed.

I remember we met with the psychiatrist at OHSU and they had a protocol where they offered ketamine in there. They did it in the ER, they also did in their sedation suite.

So being creative with different options like that. Or could it be offered maybe during the inpatient stay, for example, as a treatment and maybe it could shorten their hospitalization?

I think there's a lot of potential avenues we could look at that are being underutilized now. Yeah, absolutely, and what that can mean for not just the system itself, the patient themselves, their hope for recovery.

And just, you know, even in all of this, thinking about, I think the idea of ketamine, whenever we talk about ketamines within the systems, when we're talking to nurses and doctors and other practitioners, The idea is that the effect of the ketamin is only for the duration.

in which the ketamine is given. Yes, the pain relief, right? The dissociative anesthesia. However, in this model, what we're seeing is there's a durability of this effect.

Can you describe that? Like, what is happening?

Dose, Durability, and Future Research

What's this difference between like, we're not just trying to turn down, it's not like we are giving them anti-anxiety medicines that are just going to work for the duration they work at.

And then once the medication is done, your prescription runs out, you know, and your anxiety may come back. Here, were saying that one dose may last you longer than just the durations of the medicine itself, right?

Yeah, exactly. You're right. Because the way ketamine works is it helps the brain rewire and form, you know, new connections of neuroplasticity. And so, again, it can help you think about a situation differently, have more cognitive flexibility, be more open-minded, and especially if there is some sort of integration happening within those first few days, like the critical period, kind of the 72 hours.

you're receiving the ketamine, if they can talk to a therapist during that time, do some journaling, you know, meditation and art, anything that works for them to help process what they experience, then that can help lead to long lasting effects.

And again, that's something that we never pay attention to in medicine. No one ever talks about this in training, but we can do things to them have the effects last longer.

Yeah. I say too, it's been said that ketamine is an anti-medication, meaning it is a medicine that enters into your body, does its thing, its acute thing early effect, which is while that medicine is within you, that dissociation.

But then as it leaves your body, it's not in your buddy for the next few days, and it still having an effect. So it is an anti-medicine that even without it being in you body there's still an affect.

And that cascade effect is where the durability factors come in. I'm sure you've seen the variety of different responses of durability, one being a noticeable noticeable difference right away and then that effect over the next few days.

And sometimes that's so variable from person to person, of course, also depending on their set and setting, which you mentioned, and working in creative ways to in the ER too, you know, with set in setting.

And the dose, right? You mentioned something about the does. Can you talk about that a little bit? Because what was the dos that was allowed in your research study?

And how did that find out? Yeah, we gave a tiny dose point to Migsburg Keg. And most protocols use 0.5 milligrams per kilogram. Yeah. Ours was smaller because that what worked for our protocols.

We were trying to find the smallest dose possible that would have You know, the least allowable monitoring to make it more comfortable for the patient to not impede the flow of the ER too much.

But interestingly, even though the dose was really small, The patient did experience some of those dissociative symptoms. They definitely felt it. It is dose dependent.

And it's also, I mean, imagine because of weight variation, there may be a different dose that may administered based on, you know patients. difference in weight.

And I've often seen that there is a difference of metabolism between, you know, somebody who has, say, more muscle or lean and so how, again, how ketamine processes through in that administration, course of the administration and thereafter is also very variable.

So there's so much to learn, so that you seem to have kind of gathered with even the dose in your research study. What would be the next steps, would you think, for further work, what are you looking into now?

Yeah, I think a lot more research is needed to determine the best dose, the time. You know, we did IV because there's a lots of literature supporting IV.

However, We had patients who declined to participate because they had needle phobias. So thinking about, you know what injections be more tolerable to them or other routes, or lozenges are kind of less.

bioavailable, but maybe patients may be more agreeable to take them. So yeah, there's just so much to be explored. And yeah we're currently working on creating a project.

We're actually collaborating with a community organization that has a homeless shelter to try to see if ketamine will help homeless youth that are in crisis.

They will help their depressive symptoms as well as kind of increase their engagement with like therapy services and all the services that this community organization offers.

So we're trying to get approval for that. Hopefully he'll go through, but yeah, there's just so much here to be studied. Wonderful. And I can just get that feeling that this is really heart-centered, meaningful work for you.

We're seeing some changes happening, even in just increasing others' awareness of the potential of this. So maybe I could switch gears a little bit towards the end here.

Mental health of emergency physicians is definitely near and dear to your heart as well. You know, can we talk a little bit about that for a second is how can the mental health of emergency physicians be addressed and supported as you're all being called to the front lines of this crisis and the crisis is kind of really at your front door.

And I know that across the country, not just in pediatric emergency rooms, but in all emergency There is an

emergency physician right now just pulling out their hair going, I don't want to do this anymore.

What can you say to those emergency physicians of what you've learned as you have gone through just in your role as wellness director and also in doing this work and how it's really maybe brought you back to this meaning centered work that you're doing?

Yeah, definitely. Yeah I'm very passionate about the mental health of physicians. I think there's a huge crisis going on. Burnout has really increased in the last few years.

Supporting Emergency Physicians and Burnout

There's been so many physicians and nurses leaving the medical field, going to non-clinical roles. And burnout, when you look at the ranking of specialties, usually emergency medicine is at top of the list because our jobs are challenging.

Yeah, we see, you know, it's constant onslaught of patients, there's exposure to death, violence, abuse, some of, the worst things that happen in society.

So it can make you jaded at times for sure. There's a lot of cases that are really challenging and We were never really taught to, to process it. Um, and so we're really trying to change the culture and make it acceptable and.

Trying to teach our colleagues and teach trainees that some of the things we see are not normal and we need to support each other. Like I tell everyone, you know, if they just had a code, like you need go step outside after for 10 minutes, go get a coffee, don't rush to the next patient.

And right now we're doing one of my colleagues initiated this great project where after every code, there's a debrief. So the whole team gets together in a room quietly with the social worker and they just check in like, you know, how things went medically, but also, psychologically like, how's everyone doing?

Just to kind of regroup process before like moving on to the rest of the day. So I think that's a nice initiative. We have started offering like peer support, individual, we have a group peer-support.

Our institution, our psychiatrists and therapists have made themselves available and it's pretty easy for physicians to get in to see them as well. They're really on board and really doing a lot of great work on trying to reduce burnout.

And yeah, I think finding like a niche within medicine or projects you're really passionate about, you know, like for me with this work, those kinds of things really help and not just being like in the grind of seeing patients, but doing something else that you passionate about and yeah it's interesting like going back to ketamine as we were talking about there was you guys probably saw there, was a study that came out where they used they studied health care workers who had like PTSD from the pandemic and had them on a protocol for I think several doses of ketamine and like all of their PTSD resolved.

which is very interesting and they had a decrease in their depression and anxiety scores. So I'm hoping like more research on that comes out too, because I think that's like an interesting potential window as well.

I thinking the numbers that we see in our center is usually the providers that come in are usually nurses, people really at the bedside, social workers, we've had therapists, psychiatrists, you know, listening and, you know, there, with patients, and there's a lot to hold.

Working hard, physically and emotionally, under conditions as they are sometimes, especially during the pandemic, definitely had an impact on mental health.

Thank you for all the work that you're doing, bringing this to the surface of, you know, awareness and education and building a program to support other providers, physicians.

You know it's an important thing that we talk about in narrative medicine too, how Neuromedicine is a kind of broad, multidisciplinary approach to kind-of recognizing the context of illness, you know, what is the story around illness.

But its impact, even between the healer and the patient, right? And the effect that it has even, doctors are humans and they work hard, but it does have an impact in the stories that we carry home and that want to do something about that connected with and also, you know, moved by and, also impacted by.

So, and burnout is a real thing. What would you say to you? I just want to insert a little bit as like the study that you quoted, Tanya, what they showed was that they did these in groups of physicians, right?

Groups of healthcare workers who were doing ketamine journeys in a community of practice. That paper by, I think they and to show that their scores came down across the board and just how powerful it is.

So let's not forget that, yeah, the burnout is real and that the healing has to happen as a community. And I think that's the part of psychedelic medicine that we're really trying to get physicians and other people in the healthcare system to understand is that healing occurs in groups, healing in relationships, in containers of safety.

It doesn't happen one-on-one. And some of what happens within two people who are burned out, are suffering from PTSD, or suffering for mental health disorders in the healthcare system is that they're doing it in isolation because there's such a stigma involved, right?

We don't talk about it. We get diagnosed. we don' reach for help. and that just makes the problem worse. But I just love how beautifully you brought in that it was these groups of practitioners who were suffering form PTSD from the pandemic who healed together.

And I think that's a really powerful statement for how the ketamine is a catalyst and the healing is occurring with the human beings that are there, right, because only we can witness.

That's the other piece of narrative medicine, that we bear witness to what we just went through. And I think one of the ways in which we suffer is when, like you said, we go from patient to patient, to patients to a patient.

Somebody just died. We don't even have the time to take 10 minutes to grieve. To come back to ourselves. to sit in a room with each other and say, oh wow, I have feelings about what just happened and I need to talk about it.

And if we can talk about it right then, that's great. But a lot of times, 90% of the time, the culture of The Emergency Room and these places is that no, we just go on to the next thing because who has time to pay attention to that, right?

So those two things are connected in this really interesting way is, yeah, debrief. And then if you can debrieve and we're in PTSD, go do a group journey.

Connection is the key, connecting in ways that somebody can talk to, somebody that can maybe empathize or even have compassion with. Everyone's in it together and they're all facing the same challenges.

So I think, yeah, we can really support each other and that's the culture we're trying to foster. What I witnessed with patients here on the outpatient side with ketamine treatment is that, oh, you know, being in the emergency room was really challenging for them, and there was this one person who talked to them or they made a connection there in that way, or, they felt that they had a place to kind of have access to and the outreach that I've had in other hospitals for outpatient is, yeah, there are other options outside of the hospital as well.

And to have that network of connection and awareness as a group, as people who are doing the work, the research and translation of that research into real world medicine, So thank you for being part of that component because that's a very strong component of addressing is what's known, what can be seen in the academic and a busy academic center is yours.

And how is that translating over into the community and vice versa? Yeah, because I can work in many ways the Community is way ahead of the Academic Centers.

You know, you guys have already been doing this work for a long time and the research is far behind. Yeah. So you're welcome to come and do some research here.

Lots of data.

Community, Stigma, and Closing Reflections

But I think it is about a network of knowledge and knowledge sharing and community and trusting even among providers. There's a story that you holding that we all hold when we're at the bedside.

And that is also important to have a place for that in community. Thank you. Thank you so much. This was wonderful. I think that was a really good final word, Alia, from the two Curious MDs is that, you know, community is how we heal.

And it's been lovely to be in communication and community with you and to continue to see this work flourish and evolve and get to the next level. So thank you.

One final thing though. because curiosity really incites creativity and opens one to other ways and alternatives and thinking sometimes outside the box and sometimes poking at things that we take as status quo.

What would be a question of curiosity that you would like to ask us or ask the audience or for your next place of exploration? in this kind of work. Let me think about it.

I think how can we work toward reducing the stigma of psychedelic medicine and bring it to mainstream medicine? Yeah, great question. I love it, well said.

Yeah, that's a great question. The word psychedelic even, coming to terms with that term of psychedelics, mind manifesting, open mind aware, it has connotations in academic and conventional medicine of psychodelics.

Yeah, great question. Maybe we'll take that on in our next podcast. Thank you. All right. Yeah. Leaving that question with our audience, thank you so much.

This has been The Two Curious MDs and we will see you next time. We challenge you to ask us those unasked questions that you're curious about in your medical practice, condition, health and wellness.

If you enjoyed the podcast, don't forget to subscribe, share it with somebody just as curious and leave us a review. It helps us keep the curiosity alive.

Post or comment with a question or curious inquiry that have and seek to explore or learn with us. Stay curious, and we'll see you next time.