Music (00:00):

[intro music]

Dr. Camp (00:05):

Welcome to LungFIT, pulmonary rehabilitation podcast, which is dedicated to topics related to the practice and research of pulmonary rehab. I'm your host, Dr. Pat camp. I'm a physiotherapist and researcher at the University of British Columbia in Vancouver, Canada.

Dr. Camp (00:30):

On today's episode. I'm so pleased to welcome Dr. Clarice Tang to the show. Dr. Tang is an accredited physiotherapist, and she's also the director of the physiotherapy program at Western Sydney university in Australia. Clarice has an established track record in chronic disease management and expertise in co-design methodology. And she's been awarded numerous competitive research grants for her work and all sorts of areas like involving consumers in co-creating engaging active health management programs. She's got research and clinical experience and working with people diagnosed with chronic respiratory diseases and in particular from disadvantaged communities, such as ethnic minority groups, she's really also heavily influenced by her own personal experience As a migrant in Australia, she's really passionate about improving engagements and health outcomes for people with chronic disease and in particular individuals from diverse cultural and linguistic communities. So that's what we're going to talk about today. So welcome to the LungFIT podcast Clarice.

Dr. Tang (01:35):

Thanks Pat for having me.

Dr. Camp (01:38):

So Clarice you and I have worked together actually for awhile on programming for the scientific content for the pulmonary rehab assembly at the 2021 ATS conference. So we've had some really interesting conversations about optimizing care for individuals with chronic lung disease. You've been involved in a number of interesting projects, too, including exercise programs for individuals discharged from hospital after an AECOPD and different kinds of health services, delivery, research related to physio practice and emergency department. And like I mentioned before, you've got all sorts of grants looking at self-management strategies and health literacy, and that focused on people who are from culturally and linguistically diverse communities is a very specific term that you've used in your grants and in your paper. So I'm wondering if you could start by telling us what do you mean by culturally and linguistically diverse communities.

Dr. Tang (02:35):

The culturally and linguistically diverse communities or otherwise known as CALD is a really common term that is used mainly in Australia to describe a group of people who are from a culturally and linguistically diverse background who are different from the dominant cultural or linguistic group of the nation. Some of the common terms are people may be more familiar with are things like ethnicity, or we sometimes call them minor minority ethnic groups or using specific names of our cultural backgrounds like Hispanics, Asians BAEM as well is a really common term used in the United Kingdom. Which stands for black and Asian ethnic minorities. So essentially what I'm actually passionate about is looking at this group of people who actually come from a different cultural background and also, or speak a different language from the dominant cultural language group in Australia. So for example, in Australia where the

dominant language is English and the dominant cultural group is the Anglo-Saxon group. People who therefore do not speak English. So such as from a Vietnamese or Arabic speaking backgrounds, or do not follow these cultural beliefs would then be characterized as being from CALD groups. And if I may add, I think this is an important clarification because often people just simply assume that people from CALD communities are simply people who do not speak English. And it is actually a much broader term than just focusing on this linguistic differences.

Dr. Camp (04:14):

And so you mentioned that there are linguistic differences, there are cultural differences. Are there other sort of typical characteristics that these communities may share regardless of where they are in the world?

Dr. Tang (04:27):

Yeah. So a number of them actually come from a migrant kind of background. So for example, in Australia itself your CALD communities are started to the white Australian movement or due to the migration movements that happened pretty much post world war two where we had a big influx of migrants, mainly from the European nations that actually migrated to Australia in more recent times, we are also seeing that the CALD communities are getting increasingly diverse with inclusions of people from a skill migration background, mainly Asian countries and middle Eastern countries, but also includes people who are displaced due to political and also social reasons from their home country. And in the more recent years, we are seeing a big group of Afghan and Syrian refugees coming into Australia due to political and national unrest in their home country. So,

Dr. Camp (05:24):

So to clarify then, can you also say that these communities are diverse in respect to say financial status or education? I think sometimes when we hear someone referring to you know, a culturally and linguistically diverse community, we're just also assuming that that group is also somehow has issues with maybe access of services and things like that, but they could also be potentially coming from affluent countries or they have means, and they have high levels of education. It's not necessarily to put this label on communities that are underserved or marginalized in any way, is that correct?

Dr. Tang (06:03):

Yes. Yes. That's precisely the case. I think often they have this understood as they are just people who are coming from socially disadvantage, actually backgrounds, but there are a clear sizeable population of people from CALD communities who identify themselves as CALD's. For example, someone like myself who are highly educated and fairly good pay or have stable employment, but they do identify themselves as being from a CALD community.

Dr. Camp (06:31):

So why in healthcare, is it important to have an understanding of CALD communities?

Dr. Tang (06:38):

I think firstly, I think there are two key kind of important factors here. So one is there's often actually commonly perceived that there are not many of us within the country or within the nation, but in actual fact, if we look at these statistics or the migration statistics in UK, us Canada, and in Australia, it is not difficult to say that our, these four key countries, 30 to 50% of the population actually comprises of

people from migrant communities. Now, in addition to that, if you look at Australia alone, one in five, people speak a language other than English at home, which actually tells you that we are talking about 20% of our population in Australia, actually falling under this group of cultural and linguistically diverse communities. So it's actually a lot more than what people commonly think there are. And then the other thing also to note is the the prevalence of chronic respiratory disease among our CALD communities.

Dr. Tang (07:40):

For example, in COPD, if we look at the BOLD study by Sonia Buist and colleagues in 2007, it does highlight that the prevalence of COPD was higher in countries like Poland, Manila, and also in Cape town, in African nations. And in more recent times, okay. Where we did the geographic distribution of the prevalence of COPD in the world, it was found that COPD was more prevalent in continents in Asia and also in Africa, the nations that are actually have higher smoking rates. If I may say, which while we know smoking is not the only factor that leads to chronic respiratory disease, it is one of the key risk factors to it. So people might still think, okay, well, you might be talking only about 20% of the population. I do feel that often people forget that some of these CALD communities are actually more prevalent because of the genetic predisposition and also family history that actually increases their risk of actually developing these chronic respiratory diseases.

Dr. Tang (08:43):

And therefore attention actually should be spent on this group of people as well. And then last but not least, I think is also understanding that while I think pat you've made a really good point that not everyone from CALD communities actually fall under the socially disadvantaged group, a sizable proportion of this group, of people within the CALD communities, are actually from a lower social economic background and therefore tend to have poorer health outcomes due to factors such as lower level of health literacy, and also other contributing factors like varying beliefs in models of care and also trust within the national health system and due to these kind of combination of reasons their health outcomes are in the poorer. And they are actually the people who most likely going to benefit from our non invasive or non-pharmacological self-management strategies that have plenty of evidence actually supporting that effectiveness efficacy for it.

Dr. Tang (09:46):

And if I may draw on the more recent example, we'll use COVID something that doesn't really require further introduction. I think there's no doubt from the media around the world. That part from the fact that there is this emphasis on the mortality rates associated with COVID more importantly, the recent media reports are talking about the health disparities that actually occurring as a result of COVID. So even in UK, us and Canada, Australia, people from ethnic minority groups are actually twice or three times more likely to die from COVID as compared to the general population. And this then against that light, the to others that there is a degree of health disparities among the different ethnic groups. And we do need to actually take some time or take a step back and actually reflect on what we actually currently offering and how we can actually better include this 20% or this more group of people into better provision of healthcare services for them.

Dr. Camp (10:51):

And that's really interesting because, you know, I think that if you think about where pulmonary rehab is often clustered in cities and you might be in a, in a city and a country that you think, well, I'm not sure if this is that relevant to me. I feel like, you know, when I look around, I, I don't think that these

populations exist, but when you think about the displacement of people around the world, people are having to leave their countries for war and famine and, and climate change. And with a lot of those come like you say, lung disease. And so it is quite likely that even if you're any community in the world, you may have a CALD community, a culturally and linguistically diverse community right there. And then of course, it's not just displacement. When we think about from one country or another, we think about the indigenous people who were not displaced by coming from one country to maybe where we live that of course colonialism was the action of displacement and continues to displace people. And so certainly there's thinking about people that are coming to the country or people that have always been here and how they may end up representing a community. So when we think about pulmonary rehab, do you think that our programs, you know, the way that they're designed and we've both been involved in lots of different work in our national societies get, so we have a good understanding, I think about what is a quality rehab program. What is a typical rehab program look like. Are our programs designed to support people from CALD communities?

Dr. Tang (12:25):

Yeah, that's a really good question. And I think that the answer to that question is maybe rather than a no or yes, I think the reason why I hesitate about saying is it's not catering to the cultural needs of the community is because I think due to the variety or the diversity in cultures across the world, there will be some certain aspects of culture that of the program that the individual can identify with. But at the same time, there's also another component of the program that sometimes people just can't work it out. Or if I see the benefit of it due to the way it's actually currently explained. So I'll give an example for pulmonary rehab. I talk about the combination of a multidisciplinary education and exercise program. And for many people from CALD communities, they can understand the rationale of needing to be educated about the disease.

Dr. Tang (13:21):

And also understanding or learning ways to better manage their health condition. But when I asked an interview, people from CALD communities about what is the perception of exercise, you get that comment of, not sure why I need to do exercise. Can I see this helping me with my breathlessness? And that is actually a common thing that people don't really identify. If I may say with this, I always say whether it's a Western medical model of care or some solar, but they don't actually identify with this ideology, that exercise by strengthening, we, we know the benefits of exercise, sorry, by strengthening your muscles, they're helping you to maintain your overall cardiovascular fitness. This is actually going to help you with improvement of your quality of life, but they can't actually draw that connection. So I think what we as a program actually need to do is really to identify elements of that program that doesn't really quite identify with this population.

Dr. Tang (14:15):

I think one thing I wanted to emphasize is instead of just throwing the baby out of the bath water and saying that we need to completely revamp pulmonary rehab for people from Cald communities, I think we do actually need to think about what are some of the subtle ways that we could actually just adapt pulmonary rehab so that you can be actually more culturally sensitive for this group of people. So using example, it could about the language that we are using or the messages that we are sending. So when now we are talking about exercise, often drawing on my own personal experience and also experience with working with people from Asian communities. They always think that exercise means carrying heavy weights, it means breathing heavier, and it means breaking out a sweat and to them, that's a very

daunting prospect, but for them, if you could explain to them in terms of, oh, we are going to time this exercise with your breathing.

Dr. Tang (15:10):

And so they can actually then see that, oh, these exercise are actually connected to my breathing. I've got COPD. So my breathing is not so good. So then they can actually see that connection and therefore start participating in pulmonary rehabilitation and do think that that says something and I'm really hypothesizing at the moment, but that's something that we actually need to do in the future, looking at how we can make these changes to elements of pulmonary rehab, but maintaining the fundamental concepts and frameworks that have been actually supported by years of evidence so that we can still deliver an evidence-based, but a culturally appropriate program for people from CALD communities. I think the other thing I, if I may add as well, pat, is I do think more work actually kind of needs to be done in terms of how we sell pulmonary rehab to this audience.

Dr. Tang (16:02):

So recent study that I've actually done looking at a group of people with COPD that are coming into the inpatient respiratory clinic for the, COPD management actually found that as many as 40% of this group of people self identified to be from a CALD background, but more importantly, the people, regardless of whether they could speak English or not, the level of awareness of pulmonary rehab programs among people from Cald backgrounds were extremely low as compared to the general population. So people from Cal backgrounds were three times as unlikely to know about pulmonary rehab. So they don't even know what pulmonary rehab is in the first place, let alone be given the opportunity to be exposed to this evidence-based intervention. So I think more work if we, if we were to do any work, maybe to actually think of a way to better sell this message to this group of people so that we can actually encourage them to even try and experience what pulmonary rehab is like first. And then we can tweak how pulmonary rehab can be so that we can develop this culturally sensitive approach to delivery of pulmonary rehab.

Dr. Camp (17:15):

Do you find that also patients may be on the receiving end of bias when it comes to referrals and it may even not be, I mean, it may be malicious, but it may also be just the, oh, well, their English isn't great. They might be uncomfortable on the program. You know, they, the family might not be able to help them, you know, certainly there's lots of, of things that can be barriers for anybody trying to access Pulmonary rehab. But do you get a sense that maybe they're not even being referred because of either explicit, implicit bias, you know, from the point of view of the, of the health care provider?

Dr. Tang (17:54):

Hmm. Yeah, that's a really good point. So when I was doing this study that looked at the people who are actually attending a respiratory inpatient clinic with COPD, we didn't really find a significant difference in the number of referrals to pulmonary rehab between the CALD group versus non CaLD group. I didn't think so when we did further analysis of that data, interestingly, the English language seems to be one independent factor that is associated with referral rates to pulmonary rehab, which kinds of indicates that there may be some implicit or explicit kind of, action, where the referral perceive that the person who has a poor command of English will be, unlikely to participate in pulmonary rehab and therefore may not have given them the option of pulmonary rehab. I think before we go on to say that the problem is to do with internal, external biases towards people from CALD communities.

Dr. Tang (18:59):

We also need to understand the situation that the referrals to pulmonary rehab are in so many of the times, these health professionals who are referring to pulmonary rehab work in conditions that are limited with resources and time. So if you do have a patient that requires language assistance, for example, it takes two or three on sometimes three times longer to explain a simple concept due to the forward and backward translations from an interpreter and therefore it again robs the opportunity for the health professional to really sit down and consult and then have an active discussion with the patient about whether they should be actually going to pulmonary rehab or not. And I think that also plays a big factor in why we are not seeing as many referrals to pulmonary rehab from CALD communities

Dr. Camp (19:56):

Well, it is encouraging that some, I mean, we know referrals to pulmonary rehab is low anyway, I've just across the board, but it is encouraging to hear that in your study that, that didn't appear to be a huge contributing factor, but, but did you get a sense either from, you know, your experience clinically or from the study, what other kinds of barriers that people from CALD communities are facing either when accessing or participated you've mentioned of course, language and even just the messaging about some of the interventions, but have other things come up as well?

Dr. Tang (20:29):

Hmm. That's a really good question. I think the other thing is really about how they actually associate themselves with the Western medical model of care. I think in Western medical models there is a big emphasis on the patient actually deciding and dictating their health and making a very important health decisions such as whether they participate in pulmonary rehab or not actually. But in a lot of cultural groups, families are actually a big part of decision-makers and as much as I know it doesn't sit very well with the Western medical models. If I can draw an example again, using people from Asian communities, families are a big part of the way we grow up. And majority of the time a health decision is made in consultation with the entire family rather than by the individual. So often I think the other barrier that people face when being offered to participate in pulmonary rehab is that they themselves are not very confident in making that decision and often wants to seek an opinion from their family, but families are often excluded from this consultation process.

Dr. Tang (21:43):

So I think that's another added area to participation in pulmonary rehab, apart from the linguistic and apart from the messaging. I think the other thing really to be mindful about is the ability for us to create this culturally safe environment, to entice people from CALD communities to participate in pulmonary rehab. So cultural safety is ongoing work. How we develop a culturally safe environment is actually an ongoing process, but it does involve the people feeling comfortable and feeling that they could trust the health professional when they are put into situations perhaps where majority of the conversations may not be held in, in a language that they are comfortable in. So I'm not to say that these people are not speaking English, but if people feel that they will be discriminated or they feel that they are subjected to stereotypical perceptions about how their behaviors are going to be, then it is unlikely that these people are going to participate because none of us want to be subjected or put into in this environment. And I think that's another barrier that they face is around the fears of what the society perceive of them and also potential racism or discrimination. There's no coming necessarily just from health professionals, but from other participants within the program. And I think the way forward is really looking at how we can

build this culturally safe environment so that anyone, regardless of your cultural linguistic abilities can participate in pulmonary rehab.

Dr. Camp (23:25):

No, I think your comment about the family's involvement, you know, that really resonates because you think a lot about how, you know, I'm a physical therapist and trained in Canada. And so much of what we talk about is around confidentiality of patients, information consent from the patient. Making sure that other people are not answering for the patient, but that you're getting, you know, what their experience is. And so if you're using an assessment and the family chimes in about what the answers should be, you're supposed to like, oh, it's supposed to come from and how that really can collide with how people are handling their, their health and their healthcare decisions. And like you say, many parts of the world. And so, you know, if our rehab program and our refers are in this sort of one-to-one, and we're very much, this is what's happening, this is, we could really misperceive that as being sort of lack of interest when really, as you say there's a lot more important discussions that need to happen with more people in order for that person to make the decision with in the context of their family to come.

Dr. Camp (24:35):

So that I think that, that, that's a great example about how our training and how, how our system is organized, can really not work for a lot of the people that may be referred to us.

Dr. Tang (24:47):

Yes. And I think the other thing also is, look, I think there's two ways to this issue as well is the use of interpreters often. People believe that just because I have an interpreter present at my consultation, it means I address the language barriers, but often people from CALD backgrounds, not that that they don't trust an interpreter. They might actually not want an interpreter because they rather their family members to be present because they trust their family members more than a stranger in the room today, if I may say, and also in some cultural groups, the population is so small that the interpreters actually sometimes potentially even know the patients themselves and therefore family and family reputations in some cultural groups are very important. And therefore, if they will try to disclose intimate details or things that potentially may not be shining a favorable light on the family, then people from these cultural groups, don't tend to voice it out in front of an interpreter who potentially knows this family.

Dr. Tang (25:53):

So I think these are some of the issues that people sometimes forget. I think when we are using interpreters as well. And I'm not just to say that they are not, we shouldn't use interpreters. I think firstly, it will be wise if we could provide people that option of whether they would like an interpreter or not to begin with and if they don't where they want to bring a family member into so that they themselves has that they're empowered to actually make that decision rather than we as health professionals make that decision by before for them.

Dr. Camp (26:26):

Yeah. And I, I think that you've already offered so many really practical suggestions for what pulmonary rehab programs can do, you know, starting say with the referral who needs to be there at the assessment. When we first talk about what this program is asking people about their perceptions of education, exercise, physical activity, and then thinking about how the, how the family should be

involved, could be involved. It all depends on, of course, like you say, what that cultural group and then what that person's decisions are around that. What other changes do you see that could happen to make a program more inclusive? And I'm really interested in maybe your thoughts around that comment about, you know, racism and discrimination that happens in the healthcare system. And it can happen by, like you said, the potential of other participants making it not a culturally safe place. So what can a pulmonary rehab healthcare providers do to make that environment as safe as possible?

Dr. Tang (27:29):

Yes, no, that is actually a really good question Pat. Firstly, why I I'm personally not a big person of training. I think we do need to also look at realistically providing some training to help professionals and how we can create a culturally safe environment. And I think to that first, firstly, we require the health professionals themselves to be open-minded to some of the proposed changes. So one thing I really am quite vocal about this. I don't like the mandation that everyone needs to actually do a culturally safe program because I don't actually see that sometimes often think that really turns people away from participating in training because they see this as a chore rather than actually something that they want to do to improve the quality of services that they're providing for their patients. So I think firstly it's really, as an educator myself, is how I can inspire the next generation to actually be more open-minded first of all, to be accepting that the fact that we may need to change some of our initial beliefs about the medical model.

Dr. Tang (28:46):

So it might so to include people from other minority groups into evidence-based intervention program, and then once they are actually more open-minded or receptive to this concept, then providing them with the training to become how around, how to create a culturally safe environment. We're pretty would be the next step. And then they also include educating others and from the community. So I think this approach will require kind of partnership with community leaders with the public health partners and with government to shine the light, to educate the public about the diversity within the community and how we could go around respecting each other, not so much about the fact that we have to welcome each other's with open arms, but it's about respect, I think is the key thing, creating this environment where people, respect each other's rights to choose their cultural beliefs and respect differences in opinions. And then I think once we get there, the environment will be potentially more safer for people from other cultural and linguistically diverse communities to participate in.

Dr. Camp (29:59):

And you know, I think sometimes when discussions regarding change happen, there can be a flavor to it that it feels like, oh, we'll have to, we have to change our program to meet the needs of this community. And you know, I guess, I guess we'll do it sort of feels like an inconvenience, but I like to always think about like, what are the things that the program is missing by not changing? You know, there are interesting perspectives. There are better ways to think about exercise. There are novel ways to think about education or self-management, you know, our Western model is very narrow. So what are we missing as programs by not adapting?

Dr. Tang (30:40):

I think firstly, but not adapting missing out on that 20% of the population that I've actually talked about earlier. And I think the other thing is, and we do need to consider it in context. We need to consider that like what you say earlier that the attendance or participation in pulmonary rehab is low worldwide,

where as low as 10 to 15%. So if we quit even just tap into these 20% population and then carry 5% of these people to participate, then we'll have impact on our overall attendance and re uptakes and completion rates or pulmonary rehab. And by not adapting as well, like what I say it means that the people who could potentially gain the most amount of benefits from the pulmonary rehab and not even receiving the service and in return, what happens is that they are the ones who are more likely to you take up a bit space in a hospital system and it becomes, don't really like to use that word, but becomes a bigger burden to the healthcare system. And actually from a cost benefit perspective is actually becomes more costly to actually treat people from CALD communities due to the fact that they are not exposed to the key prevention or self-management strategies that are commonly offered to the general public. So I think, I hope these factors are really the key in terms of why we should think about making some of these changes to include this group of people from CALD communities.

Dr. Camp (32:15):

And I think our programs have to become more rich and interesting and evolve. I think if we had a wider perspective and I think, you know, we, we don't maybe include representatives from different groups, patients on our planning teams as much as we should and could. And I think that we're we're, we are missing out, we're missing out on just rich representation, you know, and perspectives. I mean the perspectives of health across the world are incredibly wise. And I think that we would learn a lot if we thought a little bit about moving beyond just our rather tightly structured pulmonary rehab program, the way that it is now, now research is near and dear to both our hearts. And I'm curious, I know that you probably have a hundred research questions that you want to explore in this area, but what if you could just share a little bit about where your research is going, how you see the different kinds of partnerships that need to happen in order to make your research possible and you know, just where, where is this field moving and, and how can it really, I think, advanced pulmonary rehab?

Dr. Tang (33:25):

Yeah. So I think the first step we I'm actually doing is doing a bit of an exploration kind of study in understanding people's experience and perceptions in participating or engaging in pulmonary rehab among people from CALD communities. I think this is a really, if I've put, say a missing puzzle or a missing piece of the puzzle in the literature where we have a lot of assumptions about what people from CALD communities perceive pulmonary rehab to be as this inaccessible or inconvenient kind of intervention. But there are hardly any, or no studies that I know of today, the actually asked people from CALD backgrounds, what they really think pulmonary rehab should be, or if they are given the choice to not say design, not say redesign in pulmonary rehab, maybe they are given a choice to design a program that includes the key components of pulmonary rehab. Then how would that program actually look like?

Dr. Tang (34:25):

So that's really lack of this consultation or partnership with consumers, which is probably where I would think the, my kind of future research direction is actually going in. I think in addition, I'm also doing another piece at the moment about exploring perceptions of treatment or how health professionals and how they are actually what's the perception is when it comes to referring people from CALD communities to pulmonary rehab. And it's actually showing some really interesting kind of findings around where people's kind of preconceived perceptions actually going to be. And I think if we could unpack that a little bit more, that will have a big impact on identifying ways that we could train and also better message the effectiveness of pulmonary rehab meditation within the health professionals. And

then it will help to also address the issues around lack of awareness of pulmonary rehab among people from CALD communities.

Dr. Tang (35:30):

I think some of these kinds of next, my really my next step is to really tap into some of my co-design kind of methodology where I've been using lots of experienced co-design methodologies to design other health interventions, such as pre habitations for men with prostate cancers and also other types of health programs, which involves partnering with community leaders, consumers, and most importantly, people who actually live within the community and have that shared experience or journey navigating the health condition. So I'll be really interested to speak or partner with people who are interested in embarking on this co-design journey with me, because I think the next step to create this culturally appropriate pulmonary rehab environment is to get our consumers involved in not only in just seeking their opinion or completing a satisfaction survey, but getting them actively involved in designing and actually helping us to co-create, what we call co-create and to disseminate this evidence-based intervention to improve the outcomes of people with chronic health conditions.

Dr. Camp (36:53):

Clarice I just want to thank you so much for taking the time to talk to us today. I've learned a lot about culturally and linguistically diverse communities. I hope that the listeners have really taken to heart some of the suggestions and really had maybe a look around their own community and their program and, you know, give some thought as to what changes even small changes, I think, to make a big difference. And you've given us some great suggestions. If you want to hear more about Dr. Tang's research, feel free to explore some of the publications on her faculty page. And I'll put that link in the show notes. And it sounds like she, you know, would be probably quite interested in hearing if there's other people doing this work around the world. So, you know, you can certainly reach out to her. So thanks again so much, Clarice for taking the time to talk to us today.

Dr. Tang (37:46):

Thank you so much, Pat, and thank you everyone for taking the time to listen to this podcast. It's been a pleasure.

Dr. Camp (37:54):

Thank you. Thank you to all our listeners for joining us today on this episode. And until next time, keep moving. Everyone take care. Bye-Bye

Thanks for listening to lung fit. Show notes and transcripts can be found on our webpage at lungfit.med.ubc.ca. If you found this episode interesting and helpful, please consider reviewing the show on iTunes and tell your friends and colleagues. If you want to suggest a topic for a show, please leave a comment on our webpage. Thanks for listening.