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** * * Intro Music * * **

Welcome to Supplementing Health, a podcast presented by Advanced Orthomolecular Research. We are all about applying evidence based and effective dietary lifestyle and natural health product strategies for your optimal health. In each episode, we will feature very engaging clinicians and experts from the world of functional and naturopathic medicine to help achieve our mission to empower people to lead their best lives naturally.

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[1:10] *Cassy Price*: Hi there, welcome to Supplementing Health. I am pleased to be welcoming back Dr. Margaret Seide to continue our discussion on racism and health. Thanks for joining me today Dr. Seide.

[1:20] Dr. Margaret Seide: Of course, thank you. Happy to lend my voice to this really important dialogue that needs to be had in America.

[1:27] Last time we chatted, we were talking about how racism has been built into the medical systems starting at the educational level and some of the ways that is impacting the care citizens are receiving. As you've been explaining, there seems to be a well-established history of black and brown bodies being overlooked or neglected in the medical system. We see this with the increased risk of maternal death, negligence related to pain management and now with increased risk of covid morbidity. It seems clear that there is a huge blindspot in medical education in assessment and management of BIPOC patients. Where do you see the opportunity for improvement in medical education?

[2:12] *Dr. Margaret Seide:* Well, I would say for myself that when I was coming up in medical school and I had my professors and my attendings who were brining me up in my residency, their opinions were everything to me. Because it is your grades, because you want to make a good impression, the stakes are high – literally it's life or death – and you want also be a good student. Most people in medicine are really passionate about what they do. So, if you're looking up to someone and they're sending you messages about what to do and what not to do, it's going to be extremely influential. I have been part and next to discussions that were overtly racist.

[3:02] An example that I can tell you about is being a resident. I was interviewing a patient and when I was discussing the patient with my attending, one of the stressors the patient had in her

life was her romantic partner was having extramarital affairs. The attending I was talking to was a woman of colour, she was Indian, and she said to me “Well, you know what, there really is infidelity in a lot of black relationships and in certain neighbourhoods.” And, I stayed quiet. I couldn’t really talk and say “you’re dead wrong and why would you say something like that?” for a couple of reasons – that was my attending, and in medicine you just smile and nod. Your higher up is everything and you try to be as compliant and as good and as quiet as a student as you possibly can be. So, I didn’t say anything, but I know these messages are pouring down on medical students and residents. Some things that are overtly said and somethings that are not overtly said. You are shaping how that future doctor or young doctor in training shows-up when they present at the bed side or when they’re interacting with a patient in their office.

[4:30] How to deliver bad news, how to calm a family down, how to get a person to comply – these aren’t necessarily things you’re taught outright. You’re taught how to check for appendicitis or to look into a person’s lungs, but all the rest you’re just absorbing as you go. So, if you have racist mentors and professors, that is going to be silently and sometimes not so silently passed down. Really looking at those intangibles about medicine – not just the data or which labs to check, or how to palpate a liver, but how to approach a patient, the conversation you have with a patient – All of those things need to be focused more.

[5:15] And, the attention needs to be put on the fact that you as a person in American have been exposed to biased media, biased new, biased magazines, biased advertisements and you should come to medical school with the assumption that you have biases and that if you are not vigilant and those things are not openly discussed then those things will show up in your practice. Even if that’s not your intention when you walk through the door when you start your workday in the morning. That is really how human beings work, especially in emergencies. Particularly when it comes down to the fact that in an emergency you’re making gut decisions based on a little bit of adrenaline, and “I just want to make this right”, and “I have to see my next patient”. That’s when we see a lot of the biases in medicine show up, and biases that are quantifiable.

[6:23] On great example is - this study has been done a couple times, one of the more discussed studies out of Washington, DC – where they looked at almost 500 emergency room psychiatric patients. With psychiatric emergencies, you really want to sometimes be proactive. You cannot wait until the patient becomes unruly or becomes combative. You’re trying to address those situations, and if at all possible, head them off. So, you’re really trying to make this gut decision about what does this patient need right now. What is the best thing for the whole emergency, and what is the best thing for this individual?

[7:06] In that study, it was revealed that with black patients they received almost 1400 mg of total medication in a period of 24 hours. Looking at patients, how many mg did you give this patient to calm them down, to subdue them, to sedate them because you thought they might become a problem or you perceived them to be a problem at the time. Obviously, some patients have behavioural issues. It was almost 1400 for the African American patients and almost 800 mg for the white patient.

[7:46] This was looking at patients pretty much from the same demographics. I say that just in case a person listening might think did the black person appear to be homeless which might bias a person? Which is not a racial bias. It is another type of inappropriate prejudice but this study was pretty thorough with peeling away any other possible variables where you might say "what time of day was it?" or anything like that. Interestingly enough, the physicians, nurse practitioners and providers who were doing the prescribing for the patients were majority white, but there were some African American and Hispanic. They actually displayed the same prescribing biases because they're coming up through the same system. So, they're just absorbing and doing – going off their gut reaction. Even if you see something and you're observing something like "wait this shouldn't be happening. This is racism playing out right in front of my eyes", the way the system works, you're job is to be obedient, comply, "yes sir, no sir" when you're coming up in your training or are early in your career. Plus, the fact that racism and such runs rampant in medicine. So, you already know you have a couple strikes against you. You could literally ruin your career being too vocal, too adamant, too anything.

[9:18] A pretty great example of a black doctor trying to talk about racism in medical school and she was later fired for trying to be vocal about her opinions of racism and talking to her medical school class about that. Not only is it happening, but you watch out for your own skin and you be mindful of how much you speak-up and who you speak up to, which allows it to happen.

[9:47] Going back to how do we undo this? We undo this by being open and talking about this so that every position, when they reflect on their decisions and their prescribing practices and their management of a patient, they are scrutinizing themselves. Understanding I might be racist and I do have implicit biases within me because "how could I not?", but were any of those things influencing my decision. Just being upfront with it instead of assuming that everyone is an angel, and prescribing, and managing, and processing, and following these algorithms based this purity that exists in medicine. There is a lot of goodwill and good intention in medicine, but we are also union coming up in a polluted system.

[10:42] *Cassy Price*: Now with these algorithms or health profiles that exist, is there any benefit to developing different profiles, or groupings, based on race or socioeconomic backgrounds to help improve that care?

[10:59] *Dr. Margaret Seide:* That's a tricky question because the algorithms that exist – let's say a person walks through the door with chest pains and to say "well, what's the net best thing to do?" Should you give the patient an aspirin, should you give the patient a chest x-ray? That is based on a lot of research. Although again, the research is mostly white men of a certain age and a certain weight, but it is still based on a lot of research and then you go from there. So, saying should it be different if a 50-year-old black man comes into the emergency room with chest pains, that is pretty dangerous. Because it harkens back to a black body is different. There has never ever, ever been any solid evidence that black bodies are different from white bodies. So saying different prescribing, different systems, different everything would only reinforce to a medical student, to a resident, a person coming up in medicine, to say ok – do this

for your white patients or non-minority patients and do this other thing for your minority patients. That is a slippery slope and I wouldn't want to go down that road.

[12:20] *Cassy Price*: Yeah, that makes sense. I was thinking from a genetic stand point because we have seen where certain groups have a greater affinity to lactose intolerance, or something like that. Now, I realize that obviously is not the same serious level that would see in the ER with chest pain. But, I was curious if any of those factors could play into improving that care algorithm or if they are maybe already taken into consideration.

[12:46] *Dr. Margaret Seide:* Yeah, I would say they're already taken into consideration. Yes, there are certain clusters that are around the world, certain populations where diseases tend to cluster. Let's say African Americans with sickle cells and the Jewish community and Tay–Sachs disease. So there is this sort of genetic clustering sometimes of certain illnesses, but that would actually still be – a person walks into the ER, here are the certain tests I'm going to do, or walks into my office with a specific complaint, here are the tests I am going to do – and, then if I'm suspecting based on what I see and heard in my examination I think this looks like sickle cell. Yes, my radar might be, and my suspicion might be higher for a black person who is having sickle cell symptoms, where a white person I might be looking for something else. But, I think that is baked into the sauce that is medicine. Just like if a 60 year old person came in clutching their chest and a 16 year old came in clutching their chest, my differential, my thought plan, my highest worry or my list of top 3 worries would be different.

[14:09] *Cassy Price*: Alright, yeah that totally makes sense. Now, in Canada, we have centralized healthcare so regardless of economic status you can at lease access basic health care. In the United States, your medical system is all private pay, correct?

[14:22] Dr. Maragert Seide: Mhmm, well private pay, except for the Medicare system which is for seniors and Medicaid system that is for the populations or patients that are considered disabled and are below a certain age.

[14:42] *Cassy Price*: Do you see a correlation between income inequality and racial inequality? And, if you do, does this play into the challenges minorities face when it comes to their health?

[14:55] *Dr. Margaret Seide:* I would say so. I can tell you that in certain institutions there will be a Medicaid clinic. Billing in the US really is quite a mess and it's a maze. One could argue that one billing system – in your average clinic if you have 10 billing systems they all track back to different phone numbers if you want a questions answered, different paper work, different everything. Sometimes, one insurance company can literally be divided into 10 sub-groups and so it is a literal mess. It is a dumpster fire.

[15:37] And so, one could argue, well if I have a clinic and only take insurance X that might streamline the health billing. But, I've never seen an all Blue Cross clinic, or any other "this is the only insurance that we take". Obviously, with seniors it is a bit different because there literally might be a person who specializes in geriatric patients or specialize in conditions that

really do affect elderly patients. So, they are more likely to be a Medicare like clinic. But, I've seen Medicaid clinics and they're alright. And, I've seen clinics – one of the hospitals where I was at, there was a Medicaid clinic and it was a big room with chairs where patients waited and they got to see a doctor when they're called. But, one of the issue with that is if I'm coming about certain certain mental health conditions, I may or may not want to sit in a room with 30 other people. The chairs were not comfortable. All that. And, the staff in that clinic – my interactions with them was they were nasty. As if "I don't have to behave and my job is not in jeopardy", "I don't have to say good morning or respond to your good morning".

[17:00] Literally feet away from that there was a clinic that specialized in eating disorders. Eating disorder patients are most often Caucasian, sometimes they are higher income, advantaged patients. That waiting room was first of all only about four chairs or so, we're not going to make you wait long. And, we anticipate that someone coming to address their mental health concerns is not going to want to sit in a crowd. A little bit of privacy and respect from their peers. So there were four patients, minimal waiting, there was a coffee machine, at times there were snacks out, there was a water cooler, there was carpeting. It was really different – the quality of the chairs and everything was really different.

[17:47] This was something I witnessed with my own eyes and I'll say, trying to remember, one office to the other office was probably about 15 steps away from each other.

[18:01] *Cassy Price*: That picture that you are painting, it makes me think of the scene in Save The Last Dance, when the two girls, the one is is black, one white, takes the kid to the pediatric and you see that sort of crowded waiting room. Who knows if you're going to be addressed, let alone when. I realize that is dramatized for Hollywood…

[18:26] *Dr. Margaret Seide:* But, I would honestly say there is a lot of reality though. There is a lot of truth there. I can tell you another example about a relative of mine who was taking her child to be evaluated for some neurological problems and a concern about potential ADD. And, she was telling me how the doctor was dismissive, rude, not answering her questions, not returning her calls and I was like, well let me try. Because, sometimes when you say I'm a physician and this is my relative and I have some questions, the doctor will be more likely to engage and give you that professional courtesy. Well, he didn't.

[19:11] Wouldn't answer my calls – if you're not a patient here, we're not talking to you. Mind your own business sort of a thing that I was getting on the phone from the customer service or support staff answering the phone. So, she discussed it with another relative who lives in a zip code that is considered higher end, larger homes, different school system. And, she said "Come to my kids neurologist. He is the nicest, he is so patient, so engaged, so present and so good with kids. Come to my person". It turns out when she went to that other office, it was the same physician. The exact physician. His office had two locations. One in a lower income neighborhood, and one in an upper income neighborhood. And, that's how he showed up extremely differently. It was the exact same physician with two locations.

[20:18] *Cassy Price*: It's kind of hard to imagine that someone can change so drastically just based on, like you say, that income level or that neighborhood perspective.

[21:31] *Dr. Margaret Seide:* Mhmm. Yes, and no… because a person gets used to doing something and they're going with this is what is going on in this neighborhood – they're going to be medications seeking, or they're going to drain my time. The fact is that the system is corrupt at the root. The truth is that with Medicaid, the reimbursement, a doctor can see another patient for something that takes 15 minutes and they can get a certain reimbursement. Then with Medicaid – I'm not exaggerating – they get maybe a tenth of the reimbursement. And, not that that should excuse anyone's behaviors, but that's what I mean when I say the system itself is corrupt. Literally, doctors joke all the time about how "I saw a patient and Medicaid is going to give me $11 for it, or the price of the Starbucks I bought this morning" and that's not an exaggeration.

[21:37] *Cassy Price*: Wow! Knowing that then, is there differences in the way that we need to identify and address institutional racism in different areas of the healthcare system, such as family physician's office vs. the ER vs. psychiatrists' offices, etc?

[21:55] *Dr. Margaret Seide:* I think that, again, going back to schools and being upfront and outright. Having these really frank and open discussions. I think I told you on the last episode that there are some programs that are being more progressive and having more open discussions. Certainly, that hasn't been my experience and even as a physician and continuing my education, having these cultural competency course – they were always just nothing. We were shown a video and asked these really safe questions. The assumption was "No one here is racist" and let's have a conversation based on that. Instead of a real, raw conversation. It's just not that common in medicine.

[22:45] It would great if there was actually that trend towards – you need to be observant of what is going on inside of you when you are making a decision. You need start just like if you were proof reading an order you put in or an email you were sending. You need to proofread your gut decision and check for any incidence of bias, assuming there just might be. Instead of assuming I'm a nice person who wouldn't treat anyone differently based on their race.

[23:22] *Cassy Price*: Yeah, I think people don't want to believe that they are racist or have racist tendencies. We want to believe that we're inclusive and here to help everyone. Like you said, a lot of it gets thread in early on or subconsciously. It's not even that you are consciously going "they have a different colour of skin then me, so they're more likely to be difficult" or whatever that thought process might be.

[23:44] Then certain groups, or cultures, have different beliefs or approaches to medicine. So what are some of the things that need to be addressed with concern to those different cultural approaches to seeking care. The way they want to deal with a condition.

[24:09] *Dr. Margaret Seide:* There again needs to be more education about that. The fact that, let's say in psychiatry that we might have the understanding that a man may show a more limited range of emotion. So when I am trying to decide if he is in destress, is he depressed, is he a risk for harming himself, and I am trying to read the room, I would like to add a couple points on emotions because that might be how culturally men are conditioned. Especially, above a certain age or in certain professions – let's say he is a fireman or something along those lines. I might alter my approach and sort of see things through that lens.

[24:58] the same thing also with a patient who is from an immigrant background. I might assume there may be some resistance to what I'm saying. Same with a patient who already has a certain condition, let's say they're a sickle cell patient and I know this is their 50th visit to the emergency room this year. And, that's not even an exaggeration. Some patients with chronic conditions really are in the hospital that often. I know that person's presentation when they show up, might be a little different and I would calibrate based on that.

[25:40] *Cassy Price*: Okay. Then speaking specifically related to alternative wellness, over the last decade we have seen BIPOC individuals excluded from the "wellness" space, despite the often clear appropriation of these health systems from marginalized groups. How does this exclusion, inaccessibility and constant "aspirational" tone of "wellness" impact BIPOC groups? The example I think of specifically is with moon juice where botanical adaptogens are sold with little to no regard for cultural origins and often repackaged to be inaccessible to their native groups.

[26:27] *Dr. Margaret Seide:* Mhmm. I'm not familiar with that. Is that something that is used in indigenous populations?

[26:35] *Cassy Price*: Yep

[36:18] *Dr. Margaret Seide:* The thing is with alternative health, it is considered niche and boutique. Still partly or a lot of it is. So, it may or may not be covered by insurance. Ultimately, medicine is a business. I'm going to put my business and put my advertising and my focus and my pricing is going to be where I think I can make the best dollar. And, so it is still be true that beer commercials might be seen more during a football game then a lifetime moving because that makes more sense for my dollar. That is where the system is working against itself – where it is a for profit system, especially alternative medicine that is not necessarily all covered by insurance.

[27:31] There is this assumption of black people being poor or not having the means or not necessarily caring as much about their health and so the advertisers or the people working in that system will act upon that belief even if it's not a conscious choice.

[27:50] *Cassy Price*: Ok, yeah. It seems like a lot of it is not necessarily that people are going out of their way to be racist or act in a racist manner. It's htat there have been so many little messages passed on through out their life that it started even at a young age. There have been

messages or experiences these people have had throughout their lifetime, that were not maybe even in a professional capacity, but have still coloured the way they interact with these patients.

[28:24] *Dr. Margaret Seide:* For sure! Going back to the example of the prescribing of medication which is again such a good quantifiable example. When I prescribe a medication, or I am making a decision does this person need a chest x-ray or not. I am making a decision for that patient and whatever I think is going on with that patient. But, that decision might put me at risk. We live in a very litigious society and doctors – the education about lawsuits and being careful about lawsuits and how you document this and that. We start getting that message even as medical students. And so, when I'm deciding I'm going to give this patient 10 mg of sedating medication rather than 5, that sedating medication has risks. It might be helpful for the situation, but I might harm them. I might effect their heart, I might suppress their breathing too much, whatever. So, if it determined that you gave too much medication and this patient has had this bad outcome, up to and including death, I am on the line. Every doctor worries a lot about lawsuits in their decision making, and in their documentation – how careful they are.

[29:49] So, I'm not just saying "I hate black people" and so here I am and I'm going to over prescribe this medication, or not give this patient a chest CT – even when that's the most logical choice – because I'm putting myself at risk when I deviate from the standard algorithm. In order to put yourself at risk, it would have to be so instinctive – the decision making -that is not something that people do. Everyone is protective, trying to protect their career, protect their wallet. And so, I might kick a black person on the street if it comes to that, but I'm not going prescribe you things when there's a long paper trail going back to what I prescribed and maybe what I prescribed to the white patient that came in before or after. I'm endangering myself. When a person endangers themselves to mistreat or maltreat another person, that shows it is a very, very, very gut reaction.

[30:50] This reminds me of the shootings and brutalities of officers with black bodies where I observe this situations that are so tragic, and brutal and violent. But, the Philando Castile example in particular where there was actually the woman who said I am on Facebook live and Philando is the car with a child. And, you're looking at the officer and Philando is sitting there and the officer is scared. He is scared like he is going toe to toe with a lion. Philando is sitting there in a car with his seatbelt. That there is an officer shooting a person on Facebook live, again you have really endangered yourself. Even though the judicial system may or may not convict and it's bad that he will end up in prison. I think that is secondary, cause in the moment you are making a decision. Your name will still be splashed in the newspaper, you might be on suspension, you might be in some sort of trouble, your family might be in some sort of jeopardy, there might be people picketing on your lawn. All unwanted consequences. Every cop that pulls the trigger on a black man running away, is opening himself up, endangering himself, his income, his job, his prospects, his future, his resume, in order to kill another person. That goes back to it being extremely instinctive. Our primary instinct is self preservation. When you endanger yourself in order to cause harm to someone else, that is really tell of how bias and instinctive these biases and gut reactions are.

[32:50] *Cassy Price*: From a societal and cultural perspective, do you believe movements like having Kamala Harris elected with Joe Biden and having other people in power that are of colour and that come from those various racial backgrounds will actually help to shift those inherent biases that people are now having engrained in them? I realize they are small steps and it will take time, but do you think that's moving in the right direction or do you think it layers on top of the other issues that we are seeing?

[33:31] *Dr. Margaret Seide:* I really believe that representation is important. Even putting together of the cabinet, there is more diversity, more women, the first transgender cabinet member, the first indigenous cabinet member, because when you're in the door you can let others in. The problem is, when you just got your pinky toe in the door and you're the only black person at this corporation and you're like "Oh I better not mess up", "Oh I wonder why they didn't invite me to the office party that everyone else is going to", you're tip-toeing around. You're trying to breath lightly, whisper and not take up space because you know that you have racism and possibly sexism, possibly xenophobia, genderphobia, all sorts of things going on and so you're walking lightly. When you know you're there as a person of colour and your boss or Vice President or whatever, you feel like you can relax and take up more space and spread your wings. You can say something if you see something inappropriate.

[34:43] And when you look up – if I say basketball player, you probably automatically think of a tall person, maybe of a very fit person, possibly of a black person, because that's the image that comes with that person. If I said president, vice president, even if I said who can you guess is the CEO of whatever company, it is probably a white man that comes to mind. Again, this is instinctive, gut reaction. So, when there are more BIPOC faces on the scene, it normalizes it. It makes it so that huh ok, well that actually is possible. Then the rest of the world is observing that there are different strata that a person of colour or an indigenous person can actually reach or achieve. That concept of a person not being capable or not being as motivated or having the same work ethic or intelligence have to diminish just because there are more faces of females, colour, transgender, indigenous are just more there when you turn on the news. And so, I think that representation really matters and it changes things.

[36:05] *Cassy Price*: Awesome, well thank you again. This has been another amazing conversation and I really appreciate you taking the time to chat with me again to explore this topic further. I think it is something that really affects all of us and we've seen more and more of it in the news over the last year to two years. Not that it just started, but I think people are becoming more aware and want to educate themselves more. So, these sort of opportunities are great for spreading the word, get people thinking and maybe get them looking inwards at where some of their inherent biases lay and get them to stop and pause when they're in these situations.

[36:46] *Dr. Margaret Seide:* Absolutely. Thank you very much for giving me this space to talk about it.

** * * Outro Music * * **

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