Emily: I'm Emily Kumler and this is Empowered Health. We have all felt disregarded by the medical system. At some point in time we've presented symptoms and we've either been sort of like too scared to go to the doctor, too scared to talk about something that's wrong or bothering us or we've actually gone through the process of going into the doctor or doing research on her own and feeling pretty left behind. This week we're going to get into this idea of advocating for yourself. This is a topic that's obviously really important to me. I feel like this whole podcast project has been an exercise in advocating for myself and for other women. I've been struck almost every episode that I end by saying, okay, this is just another reason why you need to advocate yourself and trust yourself and know your body. This week's guest is an expert and somebody who has dedicated her life to helping women advocate for themselves, so she's going to give us a lot of really great tips and information. I wanted to share some stats with you all. According to the New York Times[1], research shows[2] that both doctors and nurses prescribed less pain medication to women than men after surgery, even though women report more frequent and severe pain levels. And an University of Pennsylvania study[3] found that women waited 16 minutes longer than men to receive pain medication when they visited an emergency room. So some of this may sound familiar to some of us, women are also more likely to be told that their pain is psychosomatic or influenced by emotional distress. And in a survey[4], 2,400 women with chronic pain, 83% said that they felt they had experienced gender discrimination from their healthcare providers. So I mean those are some stats that certainly highlight that this is not an individual problem, but this is a systemic problem and it probably is wrapped up in gender. And I think sometimes this stuff is really hard to tease apart because are we not communicating effectively? Are we not being listened to effectively? Are doctors so stressed out and so limited in their time that they're only listening to the first few things that we say? And we try to downplay things. So we're not saying the most important things. And I think that's actually a study that I've read. So there's a lot that goes into this sort of, I mean it's almost like communication theory in a way. So I'm very excited to talk to our guests this week and I hope that you guys find this episode informative and in light of everything that's going on in the world right now with the coronavirus[5], I have been struck, again, I keep saying struck, but I feel like that is sort of the best word, by the fact that like people, you know like this idea that everybody's buying up toilet paper. And I know this is really scary and I have a mild fever right now. So like I'm not definitely not taking this lightly, but I also think like the flu kills tons of people[6] and we do not sell out of toilet paper and paper towels and like I'm having trouble getting an inhaler for my son who has asthma. So this feels a little bit crazy to me. And I think part of this is just symptomatic of our mistrust of the information that's coming out. So this episode will really focus in on how you can advocate for yourself. But in general, I think you've got to have trusted sources and you've gotta be able to rely on some data in order to make good decisions. And we also know that stress is a huge causer of problems, health problems. So as much as you can try and sort of believe in your sources and take things a day at a time, the better I say this all with the two kids who are going to be home for like the next year, apparently I'm supposed to be homeschooling them. So stress is very much on my mind too.

Christie: Hi, my name is Christie VanHorne. Emily, I want to thank you for having me on the podcast. I'm very excited to be here today. My preferred pronouns are she, her, hers, and I am a public health consultant with my own firm called CVH Consulting[7]. I have a master's degree in public health and a master's degree in education as well as a certificate in instructional design. And

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[1] https://www.nytimes.com/2018/05/03/well/live/when-doctors-downplay-womens-health-concerns.html
[2] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=383803
[3] http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2008.00100.x/full
[4] https://www.surveymonkey.com/results/SM-P5J5P29L/
[5] https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963
[6] https://www.cdc.gov/flu/about/burden/preliminary-in-season-estimates.htm
[7] https://cvhconsultingllc.com/

I've worked in women's health education and training for over 15 years. My journey started as a peace corps volunteer in South Africa and I've worked with organizations such as Planned Parenthood. I have overseen maternal and infant health grants here in New York state where I live and I've also worked for two national healthcare organizations to develop training and educational interventions for women with bleeding disorders.

Emily: I'm so excited to have you on because I feel like there's a lot about your background that I feel like is so applicable to the podcast in general. Just sort of looking at women's health and sex differences and advocacy and really sort of knowing enough to know how to ask the right questions, which I think, you know, most women just don't know that there is such a big difference between their bodies and male bodies. And I don't mean that in like the, you know, sort of bikini medicine way and like the overall regulatory systems of the body.

Christie: Our chromosomes are actually different. Yeah.

Emily: Right, right. Yeah. So how did you get into this? Like how did you sort of decide that this was going to become your life's work.

Christie: As far as devoting it to women's health and education and training?

Emily: Yeah, and like, I mean, I feel like you do a really great job of helping women sort of navigate right? And like figuring out how to get the right care for themselves.

Christie: I didn't realize I was doing that until about six months ago and another public health consultant said to me, she's like, Christie, your focus is really, you know, women's health but also patient education. And I hadn't realized then until then that that was really my entire background from the time I was in the peace corps in 2000… and I'm dating myself here, but in 2003 even then I was, I was educating people about HIV, right. Working with healthcare providers and youth to, to educate patients about what HIV was and symptoms and signs and all of those things. So it's something that I've always done and didn't even realize that I was doing.

Emily: How did you get into the peace corps?

Christie: So I spent a summer in Tanzania in between when I finished my bachelor's and started my master's degree and worked on a HIV education. So living two years in rural South Africa, 10 years after the end of apartheid. And well, the area of South Africa that I lived in during that time had the highest rates of HIV [8]of anywhere in the world. So it's hard not to be impacted by that. So when I came home, I worked for planned Parenthood for a couple of years as an educator and I will say it's still to this day, my favorite job of all time.

Emily: Oh yeah. Why is that?

Christie: Oh, it's just being an educator at Planned Parenthood, you just get to do so many things. You know, you work with teachers, you work with youth, it's empowering. It's exciting. You learned so much about, you know, reproductive health and treatments and STIs. I know that sounds bad but.

Emily: No, it's important.

Christie: Yeah. Like, it's empowering, especially when you're a young, you know, in your early twenties. So still my favorite job and it really set the foundation for the rest of my career too. So, you know, as I was working at Planned Parenthood, I started researching schools of public health and then I went into, you know, public health education.

[8] https://www.who.int/hiv/HIVCP_TZA.pdf

Emily: It's so interesting too because I feel like, did you, so when you were in the peace corps, did you know that that was the kind of work you were going to be doing when you applied? Would be the sort of like AIDS advocacy stuff?

Christie: Yeah, I mean, I became extremely passionate about AIDS awareness and education. Uh, during my time in the peace corps, there's a book actually called "Saturdays are for Funerals." ***[Editor's Note: Saturday is for Funerals]*** [9]And that was my peace corps experience. It's like, I'm not exaggerating, almost single, every single Saturday was spent at a funeral.

Emily: Wow.

Christie: Because so many people were dying of AIDS. So when I came home, I did a lot of public speaking, which is something I've always done. You know, when I got the job at planned Parenthood I, I oversaw and worked on a couple of different AIDS task forces in Rochester, New York and Western New York. So it's something that I stayed extremely involved in.

Emily: Well, and I feel like AIDS is one of these epidemics that is, I mean the interview that we were just on that held me up was, is all about cancer breast cancer screening specifically. And I feel like it's so interesting because something like AIDS, my uncle actually died of AIDS. He was like one of the first people who was like in that first cohort of people, which was a fascinating experience because people didn't really know how to handle him. Right. So like he was in New York, he was a gay man and my mom would have to go to New York and get him out of hospitals, like fairly regularly. I remember this as like, not traumatizing, but like a very impactful experience when I was young, I mean I was probably like a freshman or sophomore in high school when he was diagnosed.

Christie: Oh, yeah.

Emily: And he literally, I mean, like my mom would go into the hospital and it was like he was in a like biohazardous wing, like and nobody would've brushed his teeth for like weeks and she would be like, get him the F outta here. Like, yeah, you know, we'll have like hospice for him at home. And it was always this roller coaster where like, you know, a friend would be over and he would have blood in his urine or something and they would see it and they'd call an ambulance and it was like he wanted to die at home and so he'd get better. I remember going to New York and like taking him out to sushi and he like kind of looked like a skeleton and that it was like this really weird up and down of like saying goodbye to him multiple times. And you know, seeing him again and I laugh because it's sort of like, he was probably one of my all time favorite relatives. He was a writer and he was a novelist and definitely inspired me a lot. He used to just refer to my older sister and I as the brats, which probably pretty applicable. You know, it's interesting because I got really interested in HIV and AIDS myself and had gone to high school in Rome for a year, my junior year. When I was over there I realized that the kids like didn't have any sex ed. Whereas like I had gone to this private school in Cambridge, Massachusetts with lots of intellectual parents and you know we were talked a lot about like how to put a condom on and you know all the other things you can do besides have sex. And so when AIDS broke out it was like literally, I mean I think we all thought like you will die if you have sex. Like there wasn't a huge differentiation made between like the rates that women get it and the rates that men get it, drug use at all, you know, all the other factors that we all now sort of know more clearly about. And it was so terrifying. And I, our high school had this really great program where you could go back, You could basically develop a curriculum second semester senior year, right. You're like into college and you're sort of like not interested so much in school anymore. And so it's called senior project and you basically develop a program where you have to fulfill 40 hours a week

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[9] ***[Editor's Note: Saturday is for Funerals]***
https://books.google.com/books/about/Saturday_is_for_Funerals.html?id=1A3iPJyhpRQC&source=kp_book_description

either getting an internship or doing a variety of different things. And I decided I was going to go back to the school that I lived in. It was a boarding school in Rome and survey the kids there on their sort of like sexual habits and then do the same thing with the school in Cambridge and compare the results.

Christie: Oh, look at you.

Emily: Just see which one you know is does education make any difference basically? Cause we had one day over there where it was like supposed to be like human health day or something. I couldn't believe that there was such little knowledge about STDs.

Christie: Yeah.

Emily: And it was fascinating because the survey results basically revealed that like it doesn't really matter that like kids kind of just behave how they want. And like even if you tell them all that these sort of like scary factors, like they may not feel like they can speak up and say like put a condom on or not. And maybe some of that's changed. I mean I graduated from high school in '96 so the world was different then than it is now. But I'm fascinated to hear a little bit more about the peace corps stuff because I feel like that for me it was like sort of a foundational experience to recognize behaviors impact on health. And certainly in women's health we see this a lot because you know, there's just the idea that you have to go to your doctor and say like, oh, I know you're a prescribing this statins for me, but do you know that my, I'm going to, you know, probably develop diabetes because I'm a woman. And if you put a woman on a statin and her chances of developing diabetes[10], like go through the roof. Right? And like people don't know that kind of stuff. So when you were in South Africa, did you, I mean that first of all, it must've been incredibly heartbreaking, but how did you sort of manifest the idea that like if people have knowledge that knowledge equals power in terms of health?

Christie: Well, sometimes I think it takes more than just the knowledge, right? Like going back to public health, I also just want to mention the abstinence only education shows like results, sorry, I'm speaking for in the United States now, in States where you have abstinence only education, there are higher rates of STDs and unwanted pregnancies. And in States like New York or Massachusetts where we live, they do have comprehensive sex ed. So I just want to make that note about it. We do know that that can have positive or negative implications for teens or young people wherever they live.

Emily: Which is almost exactly what I saw in that school in Rome because they're all basically all Catholic, right? They're all told like, don't have sex until you get married, but they're all having sex.

Christie: They're all having sex. And then a lot of them end up having anal sex because they think that's quote unquote safer.

Emily: Yeah, yeah, yeah. And their still a virgin, right?

Christie: Yeah, exactly. So back to the peace corps. Yeah, it changed my life. So, and thinking about it specifically in women's health, I think about my host mother and I can use her as an example. So transient work in South Africa was just the norm, especially where I lived in. I lived in rural South Africa. So the homelands, I know a lot of people think of South Africa as developed, but not all of it is developed. One of the schools that I worked with there only got electricity about a year into my service and I didn't have running water. So not all of South Africa is developed. I just think that that's clear. Wanna to make that clear.

[10] https://onlinelibrary.wiley.com/doi/full/10.1002/dmrr.3189

Emily: And will you define transient work? What does that mean?

Christie: So my host father, I lived with a family while I was there. He worked in the coal mines about three hours away and only came home, every other month to bring, for a weekend. So this problem of men specifically having to go away for work and sending money home feeds the AIDS epidemic or did, so I'm speaking now 2003, 2004 time period. Things have changed. So I want to make that clear. So there was one man on my tiny little street of probably ten houses that I literally only met him once in two years of living in my village. He only came home at Christmas. So this is a problem when men don't live with their wives. Right. Many of them and my host mother would also joke that my father had a girlfriend where, where he lived and they know that, you know, at this time HIV rates amongst truck drivers and coal mine workers were in some areas over 80%.

Emily: Wow.

Christie: Yeah. So that really, and seeing that, you know, my host mother really knew this and knew that her chances even of possibly being infected with HIV were out of her control and then getting tested. Well, there's no reason to get tested at that time because of the stigma. And because there was no access to medications. So this obviously had a huge impact on me.

Emily: Well also, I mean I just imagine what that would be like. It's like,

Christie: Oh yeah.

Emily: You know, your husband comes home and you're sort of like expected to have sex with him, which might end up leading to your death, which is happening all around you, but you're not allowed to like probably really talk about it or get into it in any way. They don't talk about it, you know, or they didn't. Again, this was a long time ago.

Christie: I do think things have gotten better and I know think access to treatment has gotten better in the places where I lived. So that that's a positive. No, but yeah, it certainly had an impact, but I still think that training and education, knowledge is power. Right? And you can't change something until you actually know how, like for HIV, how it's transmitted. Right. So that that has to be, in my opinion, you have to know it's a problem. You have to understand the problem to solve it or to at least even start addressing it. So yeah, that's what a huge piece of my peace corps experience was. And then when I came home, I continued with that education through Planned Parenthood and advocacy. What were some similarities that you saw between what you experienced there and then either, you know, stigma or education components that you saw when you came back?

Christie: That's a great question. I think again, you see even today, right? Just women and young girls don't, I think they're more empowered and they're starting to take more control. I think we've seen really great movements happening in the past few years. You know, even the me too movement and it's a process, right? But really seeing this systemic problem of just gender bias worldwide, it might a little different in each place, but these gender norms that women have been pigeonholed in, you know, that we have to abide by these, these norms that society holds us to is hard and it impacts our health. So I do think that there's a similarity there. And just even, you know, another example is like asking a guy to put on a condom. You know, I, again, hopefully it's been a while since I was in South Africa and it's been awhile since I was an educator at Planned Parenthood. But, at that time it was sometimes like, yeah, he's never going to do that, but how do we change that paradigm so that women say, well, if you're not going to, then I'm not going to have sex with you.

Emily: Right. Well, it's almost like that idea of like, if you really believe that this action could lead to death, right? Like, is that enough to make you speak up or is it still not because you can, you know, we all have the cognitive dissidence that allows us to separate.

Christie: Yeah. I definitely don't think that it is, I think that that is where you really need long term, you know, not just education, but the behavioral change and that takes time. That's that, yeah, that's a whole nother topic to be addressed.

Emily: Well yeah, but you know it's interesting cause I feel like it seems like the work you're doing today, it feels very relevant in that same way, right? Where you're like really kind of getting women to feel like they do have ownership or and they have a really active role to play in their own health. So why don't you just tell us a little bit about the work you're doing now? Yes, absolutely.

Christie: So true. So I have created a series of health workshops to address bias in health care and also to improve patient and provider communication for patients and for health and nonprofit professionals. So really teaching people how to have better communication skills when they go to their doctors.

Emily: What's interesting to me is this idea that like women today need help going to the doctor, right? Like that sounds crazy in a way, right? Like isn't your doctor's job to like help you through the health process?

Christie: Let me start from the beginning. I read a book about a year and a half ago, Maya Dusenberry's book "Doing Harm"[11]. And as I was reading this, I was alarmed, I was shocked, you know, as somebody who's worked in health and public health and education for over 15 years, I didn't know a lot of the things she discusses in this book. And I just want to give a little bit of context to why I created these trainings and why I offer these workshops. So bias in healthcare can really be dated back thousands of years. I mean, we could really even break this down and take a hard look at hysteria and how hysteria has, you know, remains a problem in how it established this quote unquote. It's all in our heads and how difficult it is to overcome that idea. Simply put, we know that in healthcare we see bias in instances in which women or those from marginalized groups are treated differently, right?

Christie: And all other identities that can impact our care and seem endless. So sexual orientation, gender identity, if a person is disabled, their immigration status, weight, age, language, race. And the more we see these identities intersect, the more likely people are to experience discrimination. So bias leads to a number of problems including mistreatment, being misdiagnosed, not trusted, and to understand our own bodies, which then leads to long delays and diagnosis and at times even death. I think an interesting statistic to share is that if misdiagnosis were an actual disease, it would be the third leading cause of death in America[12] . That's incredible, right? It really is. I mean when you think heart disease, cancer and then if misdiagnosis were a disease it would be the third leading cause of death.

Emily: And that means like you're diagnosed with something that's not what you have or you're just not diagnosed.

Christie: Right, exactly.

Emily: Both of those are included in that.

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[11] https://www.mayadusenbery.com/book
[12] https://www.bmj.com/content/353/bmj.i2139

Christie: Like you are just completely, this happens to so many women who present with heart disease. Right.

Emily: Is that one third number specifically for women or is it for the general population?

Christie: So it's for the general population. I actually don't have the breakdown of.

Emily: Cause I'm sure for women it's worse.

Christie: Yeah, absolutely. No question. And you see this, I like to use the example of heart disease to really provide an example of this, right? So we know heart disease is the number one killer of women in America[13]. Kills many more women than breast cancer. Women with heart disease are seven times more likely to be misdiagnosed and sent home when they present with a heart problem[14]. And when they present, they're twice as likely as a man to be diagnosed with a mental health condition.

Emily: Ahh.

Christie: Right. Yes, exactly. So we know this, right? We know that medicine has developed this model of heart disease that's based on men, but women's experiences now when they present are atypical. They don't line up. So doctors are dismissing them. Even though we know that women have differing rates of health conditions, we know that we manifest symptoms differently than men and we respond to treatments differently. So just a couple of quick, another quick stat is women are actually 75% more likely to experience adverse drug reactions.[15]

Emily: Because they haven't been tested on us, right?

Christie: Exactly, yes.

Emily: I mean with heart disease, I feel like we wanted to do, I was like, we have to do an episode on heart disease. It's the leading cause of death. And then I was like, what the hell is heart disease? Like all of these other things, right. And then you start looking, I mean like the episode that we did on SCAD[16], the spontaneous coronary artery dissection was fascinating. 90 percent of SCAD patients are female[17] and yet people go to the doctor and most doctors don't even know what SCAD is. Right. So like you're having this basically precursor to a heart attack and you're often told it's a panic attack and it is not. And like they, you know, really interesting part of that, which I think made it into that episode was like, I like to have like really hard numbers on things, right? And then women's health, there just aren't most of the time. Right. And that was a great example. It was like how, what is the incidence rate of this? We have no idea because the people who started out trying to study it thought they'd get like a handful of people and they've had hundreds, maybe thousands of women. So they're like, it's considered a very rare condition. But in part because there's a very rare number of hospitals and facilities that are equipped to diagnose it.

Christie: Exactly. And then, so this is like, this is the trust gap and the knowledge gap really combined. Right? So we present with these problems, we're not trusted to know that we're experiencing something and it's not a panic attack or that it's not stress. Yes, we have stress. Yes, we have panic attacks, but when we present, we know, like if we're experiencing something that's not normal, we know it's not normal, but we're not trusted when we present our doctors for them

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[13] https://www.cdc.gov/heartdisease/facts.htm
[14] https://www.nejm.org/doi/full/10.1056/NEJM200008243430809
[15] https://www.aafp.org/afp/2009/1201/p1254.html
[16] https://empoweredhealthshow.com/scad-heart-sharonne-hayes/
[17] https://www.ncbi.nlm.nih.gov/pubmed/25406203

to actually believe us. So that's part of the problem. And then the other problem is that, you know, research has just thought that they would keep us from being included in any clinical trials for, you know, over 20 years. So that's the other problem is that we literally haven't been included in cardiovascular studies, so we don't know how the medications impact us. So yeah, it's complicated and it's infuriating.

Emily: So when somebody takes one of your workshops, what can they expect to get out of it?

Christie: Yeah, that's a great question. So I have four primary workshops. The first one actually talks about the bias and really the context of how everything we're talking about right now really continues to impact us. So has this medication been tested on women thinking about like, Oh, when I present to my doctor he doesn't trust me, but Oh, there's this really long and deep history and possible like reasons that this is the case. You know, that just thinking through like how the history of hysteria continues to impact our care today because even though hysteria was removed from the diagnostic and statistical manual in 1950, the catchall diagnosis now is, what I was trying to say is that they are having panic attacks or anxiety or some mental health condition that they're experiencing.

Emily: One of the things that's always been interesting me and I feel like this has happened to me in a doctor's office is like when you say like, I don't, you know, I have these symptoms, these things are happening. I actually had a doctor who like ran a bunch of tests that my husband, who's like a medical expert suggested that he run and I'm sure he only ran them because he has a lot of respect for my husband, which was, you know, we can talk about that for a long time, but, and then when the test came back and they were all fine, right? They were all normal and he was literally created this situation where I felt like we were against each other rather than him being on my team. Right. And so I sort of, he said something to me like, Oh, you know, Emily, you are one of the healthiest people in my practice. And at that point I was so tired that I like could barely get out of bed sometimes in the afternoon. And I was like, if I'm one of the healthiest people in your practice, I don't know what that says about your practice. So what are you telling me? And I finally looked at him after he was sort of going back and forth with these results being like, so great. And I was like, I feel like we're not on the same side of this and you're my doctor. I need you to help me figure out why I don't feel well. And it's like I know that's ballsy and most people, men or women would not feel comfortable doing that. But I just all of a sudden had this realization in his office that I was like, what is happening here where this is like oppositional help, right? Like he's basically saying, look, I've checked all these boxes, none of these boxes came back with any kind of problem and you're telling me that you still have a problem so it must be you. Right? And it was like, whoa, hold the phone. Like yeah, that's great. We can rule these things out. What's next? Right. And like even just the bedside manner of being able to say like, Hey look like you know, we're going to just keep ruling things out and I know you don't feel well. And I know that in some ways when you get these results back, it might even feel disappointing cause we don't have a diagnosis. But I want you to know that like I believe you're not feeling well and I want to help you.

Emily: I was curious to talk to somebody who was looking for this kind of guidance. So I reached out to Stephanie Parenti who is a population health coordinator whose career has mainly covered public health and reproductive health and she is one of the participants in one of Christie's workshops. So she's going to tell us all about that.

Stephanie: I think that it's really important to get people to understand how to advocate for themselves. So I've done a lot of advocating for different causes but helping people to be able to advocate for themselves is a little bit of a different animal. So I thought that it was important because this training was so interactive and really centered so much on individuals experiences that that was very different from what I had been doing. You know, I had done a lot of lobbying and you know, some political advocating and this can be a little bit different when it comes

to sitting down with somebody and letting them how to self advocate. So these were skills that I thought were really important to have.

Emily: So what were some of the big takeaways?

Stephanie: So I think that one of the biggest takeaways and whether you took this training as a professional in the field or as a patient, it's that patients are the experts on their bodies and that they know themselves best. And really empowering people with that knowledge, whether it is a healthcare professional who, who needs to remember that the person sitting in front of them is really the expert on their body and their experiences or if it's the patient who needs that empowering as well. I think that that can really help with confidence. I think a lot of people can get very nervous when talking to healthcare professionals and just reminding them that they really are their own experts and that they know themselves, their bodies and their experiences best can be very empowering for them.

Emily: You know, I think what's so interesting is that I feel like there's a little bit of a pendulum swing where it used to be that doctors were sort of the almighty, right? And you would listen to their advice and assume that they knew best. And I think in combination with the internet and also with, you know, the realization that women's bodies were just not being studied sometimes at all. And that, you know, women need to advocate for themselves more has really come to the forefront. But I always feel a little nervous about this idea that you know your body best because I think there is a reason to go to medical school, right? And like there is stuff that doctors learn in medical school that I don't know about my body. Right. And so I think when you're saying you're the expert of your body and your experiences, the undercurrent of what you're saying, and correct me if this is wrong, is that if you don't feel good right, then you don't ever let somebody tell you you should feel good. Right? Or like no one's allowed to correct that underlying intuition or instinct that something's off. But I also think that we have such a broken medical system here that you can get yourself into a really sticky situation where you don't believe your doctors but you don't know what's wrong and then you don't really trust anybody. And I think we've seen this a little bit with the maternal mortality crisis[18] where women are now scared to go to the doctor or go to the hospital to have a baby. And I wonder how you kind of make sense of all of that. Like having been on both sides where like you're advocating for patient care and certainly like women's reproductive rights and all that stuff as well as now learning this other side of it of, you know, telling women to trust their own body as. Well also, I'm sure believing that there is a need for the medical establishment.

Stephanie: Absolutely. And you're right, it's not black and white. It is a gray area. It is a situation that can be hard to navigate. But I think the more informed that we are, the better our health communications and our outcomes can be. So I certainly did take out that we are the experts on our bodies and if we do feel that something is wrong, that can kind of be that activation to go seek medical care. So there is a really great portion of the training called partners in care and how really patients and doctors should be partners in care. And like you said, we did kind of do this shift where it used to be that that health providers, that doctors were the experts, that we listened to them blindly and now we're seeing that that doesn't have to be the case. And while I don't think that we should shift away from listening to them that we can be partners in our care and that the therapeutic relationship has to be with the health provider as well as the patient.

Stephanie: And there really needs to be almost this medium. And I think part of that has to do with finding the right provider. Sometimes. I think one of the exercises we did in the training was, was like a stoplight, like red, yellow and green. And it was kind of, you know, what am I not looking for in a provider? What would be a red flag? What am I willing to kind of accept and

[18] https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html

what would my perfect provider look like? And I think it's almost going through that. And if you find that that good provider that you click with, I think that there's that rapport that's built in that, that trust that we can have in them.

Emily: Yeah, no, that makes so much sense. And I also think just the, I mean the other sort of, I dunno probably in tangible, but maybe the most important part of this whole conversation for me is time, right? It's like you don't have time with your doctor. How are you going to build trust? Right? Or like, and that's not to say that like the doctor's not listening to you or any of the other things. That would probably be disconcerting or reasons to find a new doctor. But I just think doctors are so stretched in general and we know that when patients go into a doctor's office they tend to list their least significant symptoms first. So there's all these sorts of communication gaps that happen. Are there things in the training that you took away that really made you feel personally more empowered to take a hold of your own health and charge forward?

Stephanie: There were, so you made a really good point about how we list our symptoms and how sometimes we start with ones that might not be as severe. So something that we took away in the training was really writing things down before we go into the doctor's office and Christie had provided some templates as well about health history, what we want to get out of visits. And I think if you can go in prepared, maybe writing out some of your top concerns, the points that you really feel important it is to get across. It can kind of help guide the conversation and hone in on what those top priorities are. And you're right, doctors are stretched thin, we know that that there are time constraints, but I think prioritization of the information that we're sharing with them can maybe help to mitigate that a little bit.

Emily: And were there any things that you took away from the course that you felt like were surprises or that you didn't know or you hadn't thought of at all before you took it?

Stephanie: So being a public health student, so recently I think that we are learning a lot about disparities and marginalized populations, but to really get the evidence and the foundations of these disparities from the course and how they really result in such alarming disparities in populations such as women, such as really any marginalized population was really alarming. And I think that maybe more people should know about that and hopefully that that can empower more people. Again, it was a really interactive training and it really centered on people's experiences because we hear of groups as a whole a lot. And the way that this was able to center on individual's experiences I think really highlighted what those disparities and what those biases can do to individual patients. And how they can, the results that they can have.

Emily: Well, and I would imagine as an epidemiologist too, looking at large populations, that is probably really profound.

Stephanie: Absolutely. Yes. Because sometimes you lose those details when you're looking at the bigger picture. And when you hear Christie recounting the experiences that people have had, especially women, especially women of color and what their results were, it really shows what a disservice is being done to these populations.

Emily: So tomorrow happens to be patient provider communication day. So it's a great chance to stop and think a little bit about how do you interact with the medical system and are you doing all you can to make yourself sort of healthy and an advocate for yourself. And I feel like one of the things that we didn't really touch on in this episode was really important to mention and it has come up in this sort of deep dive research that we all have been doing on this coronavirus, is that co-morbidities puts you at a greater risk of death when it comes to

this virus,[19] right? So if you have diabetes or heart disease or cancer or any of these chronic illnesses, you are much more likely to die of this virus. Now that's significant because if you have a weakened immune system and a pandemic strikes, you are going to be much more vulnerable to it and to a negative outcome. So I think it's like 27% of all of the cases have been people who have co-morbidities, but then it's like 67 or the majority of people who have died have had co-morbidities[20]. So this is something to really take seriously because the thing about chronic illness is that the best way to deal with it is to not get it right. So prevention is always the key. And we know that eating, you know, a healthy diet, getting rid of the sugar, doing high intensity exercise, functional movements, all that kind of stuff really does make a big difference when it comes to how healthy you are. And if you're super healthy and robust and strong, you're going to face these things in a much less acute way. And so I think, you know, we talked a lot this week about advocating for yourself and speaking up for yourself when you do have a problem. But I also always like to push for the fact that like if we can get ahead of the problem and not have it in the first place, maybe you don't know how to advocate for yourself so much. I know that sort of circular logic, but it's true. It's right. Like the healthiest people, you know, they're not out there advocating for themselves and there are some things we can't do anything about, right? Like there are certainly some genetic conditions and others, we can't help. But the majority of these problems facing Americans right now are preventable. So that's plug to while you're at home in isolation, I guess do some burpees, you know, spend some time cooking. Again, I feel like that's one of the easiest things to do and it's something we hardly ever do. Right? So easy to order out. Well you don't really want to order out right now. So think a little bit about some recipes that you could make every week that would be easy for you and prepare you for, you know, setting yourself up to be even healthier after this virus passes. I hope you'll join me next week. It's our one year anniversary of Empowered Health and we're really excited to be celebrating that milestone. Thanks for being on the journey with us.

Emily: I'm Emily Kumler and that was Empowered Health. Thanks for joining us. Don't forget to check out our website at empoweredhealthshow.com for all the show notes, links to everything that was mentioned in the episode as well as a chance to sign up for our newsletter and get some extra fun tidbits. See you next week.

[19] https://www.nytimes.com/2020/03/12/health/coronavirus-midlife-conditions.html
[20] http://weekly.chinacdc.cn/en/article/id/e53946e2-c6c4-41e9-9a9b-fea8db1a8f51