Announcer:

In this episode of Tim Talk a discussion about the history of racism and segregation in the medical profession with Dr. James Fullwood.

Tim Dentry:

Thank you for joining us for Tim Talk. I'm Tim Dentry, president and CEO of Northern Light Health. Through this podcast, we hope to break down barriers and race diversity. And focus on issues of racial, social, and medical justice. We want to listen and learn by tapping into the many voices of diversity that we have across our health system and our state. This podcast provides a forum for our listeners to share an experience of growth toward a culture that cares for one another. Toward a culture that cares for one another. That's what Northern Light is looking for. Our goal is to create a shared understanding of the issues that exist and find a better path forward.

Tim Dentry:

My guess today is Dr. James Fullwood a physician of podiatry at Northern Light Sebastiancook Valley Hospital. And a member of our diversity equity and inclusion council. He is a national delegate to the historic National Medical Association. Which promotes the collective interests of physicians and patients of African descent. He is also the creator of the main medical society, which is a local affiliate of NMA. In addition, Dr. Fullwood has created an international podiatry program and has traveled to Nigeria to teach in medical schools. Conduct academic research. And influence politics in an effort to create parody in medicine for underserved populations. Dr. Fullwood it's a pleasure to have you on our show.

Dr. James Fullwood:

Thank you for having me.

Tim Dentry:

And we've known each other for a couple of years now. Worked more closely together over the last year. Though crazy COVID year. But also as we committed to diversity, equity and inclusion. So working together on that council. I hope I may be allowed to call you James, is that okay?

Dr. James Fullwood:

Definitely.

Tim Dentry:

All right. So here we go. Your resume of work, my friend in the area of promoting inclusiveness and medicine is inspirational to me. I've greatly enjoyed getting to know you through our diversity equity and inclusion council of Northern Light Health. We share a path of life experience and time spent immersed in the cultures of parts of Africa. For me it was the East Africa, mainly Ethiopia. And for you West Africa. I wonder if we can start with this question for you. How has your international experience changed the way that you think about, perceive and act upon racial, social and medical justice matters universally, but also right here in Maine?

Dr. James Fullwood:

Well, let's start with the perceive. It was probably, I would say about seven years ago. I started traveling to Nigeria specifically three, four times a year. And my perception of what healthcare should be, was

very siloed, because of my experience here in the United States. That's all I had really seen outside of visiting other countries. But spending time in West Africa, it afforded me the opportunity to learn the history. Understand how their systems of healthcare developed. And that made me begin to think about our own development of our healthcare system in the United States. Because how we look back on our history, it determines how we engage our present.

Dr. James Fullwood:

The West African or rather the Nigerian healthcare entity, was specifically built to benefit the crown in Britain. It was a colony much like the United States was colonized to benefit the crown in Britain. And it was the first true development of what we call a work health system. And when the crown no longer occupied the United States, we had the revolutionary war as well as Nigeria obtaining their independence in 1960. We see this void in the advancement in development of healthcare, on both continents. So it maybe begin to do more research. So formalizing medicine in the United States came in 1910, out of Johns Hopkins with the Flexner Report, remember that. Prior to that, it was much of the traditional medicines that we call herbs, mom and pop remedies. That exist in Nigeria as well as existed in the United States. So we had a good 100 years of that.

Dr. James Fullwood:

So that Flexner Report in 1910, what it did was it began to formalize what we did today known as traditional or research based medicine. Nigeria hasn't had that ability yet to begin to develop into what we see as research based medicine. It's getting there. In 1910, here we have this thing called Jim Crow. It was separate and not equal. Separate and equal came later on. So healthcare in the country was developed in an era that was separate and not equal. And it began to make me realize that many of our today's struggle about access to care, affordability of care. We've been dealing with this for a long time.

Dr. James Fullwood:

And it makes me think Tim, here we are, a young country, the United States, 1865 to 1867 Emancipation Proclamation. Our president has been assassinated. Now, Andrew Johnson not Andrew Jackson. Andrew Johnson becomes the president. Now he has a refugee crisis on his hands, sounds familiar? Of all these new African slaves that are now refugees, not yet Americans. In an undeveloped healthcare system, how do they get healthcare? What about jobs? What about clinics, hospitals? Do these things even exist? So we find that if we look at our history, many of the things that we suffered from then we suffer from today and we're still trying to develop answers for. So that's a big, big question with very little time to dig into. But I hope that with a little bit of background and history Tim, that kind of sheds a light on where we are.

Tim Dentry:

Oh, that's terrific. And you know James, you struck several chords with me. One is that the old saying, if you don't learn from history, you learn from the past. You're doomed to repeat it. And you just cited a very good centuries old example. That's exactly, I believe what we're working with and living with right now. And used the word siloed and I absolutely resonate with that, because I think the medical industry, if you will, in our country is very siloed. And as we know, it was built upon the economic incentives for driving more high cost. More care, the end of life. More save the day when a crisis is underway. More critical care. More quaternary hospitals and things of that nature.

Tim Dentry:

As with very little done in the front end. And I think that's part of where our country was hit so hard by COVID, for example, is because we have invested enough on the front end. Whether it's herbalist. And I'm going to ask you a follow-up question on that. A more of a family oriented question, but those kinds of things. The preventative measures and more screenings. More outreach. More connection, as opposed to organizations waiting to come to us in our front door. And that's one thing, that's what I mean by a culture of caring that starts with caring for one another. Because we want to have a health system that doesn't identify itself. We don't identify ourselves as we are behind these four doors for these four walls. Behind these doors, waiting for people to come in. We have to be connected in the community and connected with people. And I think that's one of the big lessons learned for sure.

Dr. James Fullwood:

Yeah, I think you're spot on. Talking about COVID, I was in Nigeria several months ago, three times in 2020. And when COVID hit really hard, what people did, people on the ground, they went to back to 5,000 year old medicine. They went back to traditional medicines that they've used for ailments that look like COVID. And they began to market these things all throughout Africa. Not just West Africa, even South Africa. So blending the past and the future, we can do some great things. Just because of areas impoverished doesn't mean that they don't have great ideas. You think about Dr. James Smith McCune, the first African American who was trained in Scotland. He trained in Scotland in Glasgow. He began to look at traditional African American methodologies and medicine and mixed those with the contemporary medicine found in Europe.

Dr. James Fullwood:

And he became extremely famous throughout New York. He was a good friend of Frederick Douglas. He was a partner in advocating for healthcare for all. And a great abolitionist. You think about the very first two African American medical students who graduated to become doctors, guess where they're from? They're from Maine, voting university. They graduated the first two on the ground. One of those residents went back to what is modern day Liberia to create a hospital and a school. This is back in the 1800s. Early 1900s, people are coming up with these great ideas. And trying to, like you said Tim, develop ways to treat people who are in the poor underserved. And who don't have access to care. It's happened on both sides on the big pond.

Tim Dentry:

Absolutely, thank you. Human and personal stories are great ways to get across what we care about and are passionate about. I try to work that into a lot of the things that I say, because I feel like I can connect with people closer that way. And you do that, you have that gift. You shared with me a story of your grandfather. When we talked earlier this week and his vocation in non-traditional medicine. Would you mind sharing that story with our listeners? And if you can then really put it in the context of medical justice. And meaning the structural things that inhibit access to quality healthcare from your perspective.

Dr. James Fullwood:

So my grandfather Charles Fullwood, he was an amazing man. He passed away several years ago at a 100 years old. He lived during a time during Jim Crow, where African Americans had to actually pay to go to high school. He was the eldest of 12 children. So he went to work at the age of eight years old, to be able to pay for high school for his younger siblings. He always wanted to be a doctor. He wound up becoming a reverend in a local church. And was on radio up until his 90s. But his passion was herbal

medicine. Actual herbal medicine, not the ones that you find in the store. So I remember as a kid growing up in the south, him teaching me stories about when they didn't have money to go to doctors. They didn't have access to care. They didn't have roads sometimes to get to the local hospitals.

Dr. James Fullwood:

So they created their own liniments. Using St John's Ward and other traditional medicines to cure things from ant bites to mosquito bites to muscle pain to tooth ache pain. Things that people deal with on a daily basis. That it was pretty amazing that those traditional African and slave remedies are still found today in South Carolina and the Gullah country and lower Eastern North Carolina and South Carolina and Mississippi, believe it or not. They haven't gone anywhere, they're still around. And you can find that in Northern Maine. When I first got to Northern Maine, it is funny, because for example, salt pork. The salt from the pork. They would place that in the wounds in the south to draw out infection. Well, they do it up here in Maine too. Bag Balm, it seemed like Bag Balm was a cure for everything. But imagine being in rural Maine in the early 1900s and not having access to care. Black folks in the south and other rural areas had those issues. So we had to lean on our forefathers and in traditional ways of using what's around us for survival. So yeah. That he's my champion.

Tim Dentry:

Wow. Thank you both Mr. Fullwood, James and Charles. God bless him. Thank you for sharing that. I really appreciate that. Do you have any questions you'd like to ask of me?

Dr. James Fullwood:

Yes. I'm going to throw the question back at you. We've both often talked about our experiences and the way that we have interacted with other cultures. And the way we think about and perceive and act upon racial justice and social medical matters, kind of talking back and forth. I really want to know what are the structural barriers you see based upon your experience that contribute to medical equity and social justice? What do you think?

Tim Dentry:

Let me put it in the context of the, first of all my career path that was very traditional in medicine. The healthcare industry in America, but then I disconnected from that for a bit. And I spent my time internationally. And two years, as I've said before on these podcasts, living in Ethiopia. And trying to help the Ethiopians develop their hospital sector of their health system. And then the subsequent nine years, so I did international work for over a decade. I was with Johns Hopkins and of an international wing. And I traveled for the first few years in many countries, where they have different operations and clinical things and research things and all that. But then six years living in the Middle East, in Abu Dhabi. And I led to their hospitals that we were contracted to help them with their hospital infrastructure as well.

Tim Dentry:

So I had both of those perspectives, US and then international. And what I saw, what I contrasted was that, you mentioned a few minutes ago, healthcare for all. Well, in Ethiopia, the per capita income was low. They had a lot of chronic health issues and things of that nature. But they had a health plan. It was a very structured health plan. They were resource short, by every way you want to define it. But their philosophy and their commitment was healthcare for all. And we don't have that in this country. There it

was as you said, the people in Nigeria that rallied and used some of the same kinds of treatments and protocols that they had built up and passed down through the generations for thousands of years.

Tim Dentry:

And that's what a lot of the individuals did. And the people did of Ethiopia as well, is they had that community sense. I think here one of our barriers is that it's more of an individual sense. And it's more of a, "You're on your own," kind of thing. And if you have health coverage or what have you, that's one thing. But there's, "We aren't going to guarantee healthcare for all. We aren't going to commit to healthcare for all." Now, some would argue that. Some would say there, "Well, of course we do. Anyone can go in emergency department and receive care, or if you are 65 years old, you're covered in Medicare." But then when you look at the communities, and this is why I love what Northern Lights all about. And I'm so thankful that I'm here and I'm not international anymore. Because what our passion and our commitment is toward, is to great embrace with the communities where we serve. And to be community treasures there.

Tim Dentry:

You can't do that unless you are connected to the people in those communities. And you can't be connected to those people in those communities unless you appreciate and embrace and are open to and are thinking through different ways you can care for different needs within those communities. And many of those needs have gone undetected. Not to the people in the communities, but to healthcare providers. And to the healthcare economic system, which is geared more toward, like I said, the latter end of life, or highly complex procedures, et cetera. By the way, if you have health coverage. So to me and again, as I have gone out on limbs on, like I just spoke to some folks say, "Well, that's so political." It's not political to me, it's human.

Tim Dentry:

And we are blessed with the opportunity to be in a position where we can do something thing, so positive that maybe has never been done. But to really make sure that the individuals that comprise our communities, that we look at them as individuals. And we try to identify where are their gaps in our way of delivering are. In our way of reaching out, that are creating complexities in their health. And I can give many examples of that, of what's going on right now in COVID. But we're trying to be fact driven, first of all.

Tim Dentry:

So we have seen the, for example, people that are being admitted to hospitals and then having procedures and follow-up and that kind of thing. That's gone down, I really believe. And that's not just in Northern Light. It's not just in Maine, it's really across the country. And a lot of people are now talking about and analyzing, "So why is that?" And right now again, as we're recording this, we're still in the throws of COVID. So they're thinking, "Okay, it must be related to that." Yes, but what can we learn from that? Are we as accessible or are we a little less accessible? Are we going to the communities?

Tim Dentry:

I love Dr. Callender's approach to making sure that we add sufficient organ supplies. And there wasn't a sense from the community that they wanted to stay away from that kind of thing. He said he went to the community and said, "So this is what we need to do. How can we empower you? How can we work with you to do that?" To me, when we ask questions of medical justice, it's about the overarching

commitment. What are the values that we base that on? To me, it should be the values of healthcare for all. We don't have that value. So that's strike one to put it in baseball terms. And secondly, we need to have a justice driven medical delivery system by then saying, "And are we going to find out? Are we learning as much as we can about the health of the communities and the individuals within the communities?"

Tim Dentry:

So going out from that. And we're starting to do that now a bit, but we're just scratching the surface. We're doing it now because we now can be more data driven. One of the benefits of a unified electronic health records, we can mine data like crazy. So now we are determining, "Well, why is it that a given population in a given neighborhood has a higher incidence of diabetes, but why is that?" Let's not just assume that it's, "Well, it's lifestyle. It's genetic or what have you." Why don't we start asking the question, "So what can we do about it?" Because we really can influence those things. So I think it's a long-term journey. And I think that the next step then when you have the right values. And then you have the right structure of making sure you're not just waiting, but you're using data and you're going out to the communities. Then it's making sure that we gear all of our resources to really be on that front end connection, more so than we do right now.

Tim Dentry:

And that's a tough one, because we need to have financial health, economic health. And so much of the economic stimulation, if you will. And our health system isn't on the front end, it's on the back end. But we are proving right now, for example, in the vaccination initiative. We don't care that there's no economic incentive on the front end. We're doing it, because it's the right thing to do. And it's a historic thing to do. And we all will be looking back on these days, hopefully with our children and grandchildren. Hopefully when we're 100 and you're talking to your grandchildren, inspiring them just as Charles did to you. That we'll be able to say, "And you know what? When the community needed us to step up, we did it in the most caring and sensitive and accessible way we possibly could." I think it's a complex question that we're going to learn more about over time. But that's our commitment to make sure that we become masters at understanding what medical justice looks like. And what we're going to do about it.

Dr. James Fullwood:

Thank you very much. That was great.

Tim Dentry:

Thank you as well for being my honored guests and colleague and friend.

Dr. James Fullwood:

Thank you.

Tim Dentry:

And thank you our podcast listeners too. So until next time I'm Tim Dentry. Encouraging you to listen and act to promote our culture of caring, diversity and inclusion. Thank you.

Announcer:

Thank you for listening to this episode of Tim Talk. Please join us on March 18th. When we begin a new series on healthcare in Native American communities.