Welcome back to another episode of the antiracism and medicine series of the Clinical Problem Solvers podcast, where as always our goal is to equip all listeners at all levels of training with the consciousness and tools to practice antiracism in their health professions careers. Today's episode is titled Racism, Trustworthiness, and the COVID-19 Vaccine. And we're so excited for our special guests today, Dr. Giselle Corbie-Smith and Dr. Kimberly Manning. On today's episode, I'm also joined by my sis, Lash Nolan, whose voice you'll remember from Episode five on the pod, along with the newest member of our team, Dr. Jenny Tsai, who was actually a guest on Episode three of the podcast and has such an amazing time with us, obviously, that she agreed to join the team. Jenny, do you mind saying, "What's up?" to the people?

Yeah. Absolutely. I am thrilled to be joining the team, getting to hang out with smart, brilliant, beautiful people who care as deeply about health justice as I do, and not only that, are doing something about it. So, so excited to be here. Thanks, everyone, for their time.

Yes. And thank you for being here with us, Jenny. We're so excited to have you. And as Utibe mentioned, we have two very special guests today. First, I want to introduce Dr. Giselle Corbie-Smith. Dr. Corbie-Smith is the Kenan Distinguished Professor of Social Medicine and director of the Center for Health Equity Research at UNC-Chapel Hill. Dr. Corbie-Smith, thanks so much for being with us.

I'm totally thrilled, totally geeked to be here with you guys.

I'm glad you're geeked because I'm geeked too. It's going to be great.

We have a little geek fest going here.

Yes. I love it. Yes. I love this energy we have going so far, you all. And we are also so blessed to be joined by Dr. Kimberly Manning, a legend on social media, Inglewood native, and professor of medicine and associate vice chair for diversity, equity, and inclusion at Emory University. Dr. Manning, thank you so much for being with us.

Oh. Thank you so much. And I am absolutely echoing what Dr. Corbie-Smith said, Giselle. And I'm just saying I'm so thrilled to be here. It's great to be amongst all these thought leaders.
So folks, we're going to jump right in. We're quickly approaching the 11th month of the pandemic. Devastatingly, we're nearing 450,000 deaths to date here in the US. But we've also arrived at this moment of hope, right? We have not just one, but two vaccines available. So I'm going to start by pitching the first question to Dr. Manning. Why don't you share a little bit with us about what this current moment of the pandemic means to you?

Well, I think that it's interesting that this time last year, this isn't really something that I was thinking about daily, as far as me and my participation from my career. I was hearing about it and reading about it like everyone else, but wasn't thinking that much more about it. But what this time has told me is how wonderful it is to step into a moment and recognize that all of the things that you've been working toward, every moment of servant leadership and things like SNMA and SGIM and NMA and all these places that groom us up to lead have really done a good job. That we are powerful, more powerful than we realize that we are. So I think I'm in this space of gratitude that I get to be here at this point in my career at a time such as this. And I think the other thing that I'm thinking a lot about is that I'm so myself right now in this space and in my career. If you're a black American, and if you're somebody who's been othered in academic medicine and in these spaces, it is really hard to show up as your whole self. Like you said, I'm a black girl from Inglewood who was double-dutching and pop-locking on corners when I was growing up. And to be able to go somewhere and give grand rounds and use a little African-American vernacular, and tell people how I engage with my patients, and how we connect, and not just talk about racial concordance from the standpoint of what it looks like on a paper, but to show what it looks like lived out, and how it impacts our patients, I think that this is just a really important and exciting time. And I'm glad to be here.

Similar question for Dr. Corbie-Smith. We like to start off our episodes, getting to know a little bit more about you, so a little bit more of a personal question. But in 2016, when President Trump was elected for the first time, I spent the first few months asking a lot of my friends like, "Are you still hopeful? Do you still have any hope?" And I think something that came out of those conversations was the statement by Professor Cornel West, who said, "It's something to discuss what it means to have hope, but also to be a hope." I think both of you really are the manifestation of hope for a lot of people. Can you talk a little bit more about your optimism, your hope, what it means to be leaders in these spaces and in so many spaces as black women, as well?

Jenny, that's a fabulous question. This idea of hope and hopefulness, I think, it has to be part of what any of us that do health equity work embody. Otherwise, you'd never get out of bed. I mean, you have to believe that, as you shine light on these dark spaces and places, and have these kinds of conversations like we're having today, or do the work that many years ago people were telling me wasn't actual real science, you have to believe that those are going to come to light at some point. And that light will actually create this very moment that
Kimberly was talking about, this very moment where the doors opened, the windows cracked, and so many of us that have been preparing for so long are able to sort of move through, make sure the voices of our patients, our communities are heard in a way that is not in a one-down, sort of one-behind kind of way, but really sort of in their fullest power and humanity. And so I don't think you can do this work without believing in that amazing spirit of people, black and brown people, and sort of understanding and really honoring their triumphs over the years. Yeah. So for me, hope is-- I mean, that's sort of a requisite ingredient to the work around health equity. You have to believe that equity is possible, that there's a space and a place. And it will come that everyone has an opportunity to live a healthy life.

JT: 07:23

Absolutely. Professor West has this other quote that I love, that he's not an optimist, but he is a prisoner of hope. And I certainly believe and hope that all of us here will continue to be prisoners of hope because, like you said, we have to.

KM: 07:41

Yeah.

LN: 07:42

Absolutely. And now, speaking on hope, we're in this space right now where a lot of us are trying to figure out how are we going to help our communities out of this pandemic. And a lot of the conversation right now has been around the vaccine. And I know, Dr. Manning, you've been doing a lot of work around this. I don't know if you all saw, but Dr. Manning was just on BET with the Tyler Perry speaking about how we can have this conversation with our communities. And she also published a piece, More than Medical Mistrust. And in that piece, Dr. Manning, you say, "Mistrust is just the tip of a 400-year-old iceberg that needs to be chipped away from all sides." So can you tell us about what drove you to say this, and how you're chipping away through the work that you're doing right now?

KM: 08:34

Well, I think, as you all have probably heard me say before, I've never really been a fan of this idea of the word Tuskegee being synonymous with the reason why black people, specifically, say no to anything involving medicine, right? As a proud alum of Tuskegee University, and somebody who's actually a fourth-generation graduate of Tuskegee, it offends me that that word is used that way. But not just because of what it does to the beautiful legacy of this amazing institution, but also how it shortchanges us. It makes us so simple, and doesn't allow us to really look at the complexities of who black people are, which are individual people who've had individual lived experiences. Some black folks here are descendants of slavery. Some black folks here are immigrants. Some black folks here are of Hispanic origin, right? And we're just so different. And I think that part of the reason why I'm very specific about this idea that it ain't just mistrust that's making people say no-- medical mistrust that's making people say no, it's more. And so, what is that more? The more is sometimes big things, like what you see on TV, right? You turn on your TV. You see someone who looks like you, your sister, your brother shot in the back seven times at close range, and nothing really happens. You see it again with somebody running through a neighborhood, gunned down in broad daylight. You see it
And so I'm real careful when people say things to me like, "Is there a tracer in this?" I do not shut people down because I mean, when the Tuskegee-- the untreated syphilis study - excuse me - results came out, and my parents told me about what that was like, it was almost one of these things that they thought they were being punked. They could not believe that this had actually happened. And so surely, there are people who probably believe, "Why couldn't this happen again?" Right? And so I'm asking people to sort of broaden their idea about why people are saying, no. It's more than just medical mistrust connected to awful things that happened in the name of science. It is society. It is racial injustice. It is turning on your TV and seeing what you see at the capitol, and how there's such a difference in how we are all treated. And then it's also something as simple as an interaction you have with a doctor in a patient room. Your doctor comes in, mispronounces your name, right, turns their back, and types on a computer, and doesn't even look you in your eye. Doesn't remember how many kids you have, uses the wrong pronoun to describe who you are, and then asks you, "Do you want to take a COVID vaccine?" They're, "No. No. I don't want nothing from you." In addition to how I feel about all that is happening in my world, I don't want nothing from you. And I think that it's time for people to work harder. This idea of diversity, yes, it's good for us to have diverse environments, but we need to have some cultural humility that respects people enough to allow them to be individuals. So that we can kind of get to people's individual whys, recognizing that black whys matter. Your why is yours. And I am willing to slow down and hear what it is. So it's more than just "Tuskegee." Put some respect on my school's name. Tuskegee is where the airmen come from, is where veterinarians are made. Baby, it's where Dr. Manning was made and her grandmama and her great grandmama. And it is also the place that happens to be in Macon County, where something very unfortunate happened to black people. But that's a whole separate soapbox.
would I expect research to help me at all?" And that, to me, embodies exactly why this work around mistrust is just the tip of the iceberg, right? Because for all that the US Public Health Service study of untreated syphilis at Tuskegee—so let’s give it its full name and recognize who it was that actually perpetrated this unethical research, what it showed us, when a system thinks something is important, when folks in that system think something is important, and they’re able to make it happen for 40 years, despite innovations in science, despite changes in the physical structure, the social structure, and the social fabric—and so why haven’t we decided that getting black and brown people well or even getting them the vaccine is as important as a 40-year study? What have we done in our healthcare system? What have folks done in their healthcare system to ensure the inequalities that we’re seeing in terms of vaccine distribution and uptake weren’t going to happen? We’ve seen it. People lament it. And it was all over the news in March and April and May about the disparities in COVID vaccine. Well, guess what? Nothing obviously has changed. What are we doing differently now based on that? And that, to me, is the fundamental issue. This is about systems and structures and policies, norms, and practices that have led us to this point in time. And if we haven’t— I mean, if we’re in the same place it’s because we haven’t done anything differently. This is not solely about vaccine hesitancy, which is what this sort of individualistic label that we tend to sort of blame the victim of health inequalities for why they’re not able to take time off from work, to get online, to figure out where the vaccine is being taken, and to deal with the fact that there are people coming from counties and states away to come and take their slots in their communities. So let’s be real clear about why black and brown folks are not getting the vaccine. Vaccine hesitancy, concern, mistrust is really important and should not be— and should not be diminished or dismissed. But it is a symptom of a much larger issue, as Kimberly has said, about the way black and brown people are treated in this country and reflected in the way that they’re treated in our health system.

JT: 16:25

I think both of you are getting to this issue where mistrust is often framed as an uninformed belief or station, and in many ways, this decision not to get vaccinated can be very informed or a logical response to historical and contemporary insults. Can you both or one of you speak more to that? Like, how do we respect the justification of this response, while simultaneously working to move against it in some ways?

GCS: 16:53

Well, first of all, we have this ridiculous amount of misinformation around vaccines that needs to be addressed. And I’m not saying that we try to convince folks that the way we look at it as scientists are the right way to look at it. All right. This is based on our lens. But I do think that we haven’t given folks the benefit of the doubt and actually given them accurate information and the understanding of how many millions of vaccines have already been disseminated worldwide. What kinds of side effects should people-- I mean, these are the questions that my siblings are asking me. What should I expect after the vaccine? My arm is hurting me. Is that normal? I feel kind of crummy. What should I-- we haven’t given folks information
they need to make an informed choice. And this is sort of basic medical decision-making, shared decision-making 101. We haven't entrusted people and been confident-- and haven't entrusted people with the information that they need in a way that respects where they are to be able to make an informed choice.

And people can understand far more than we give them credit for. It's fascinating how there are certain groups of people that it is assumed that they will understand whatever you describe. But other groups kind of are treated as, "Because I said so." That does not work with your children, and that does not work with your patients. I have two teenage sons, and it doesn't work when I tell them to do something and just say, "Because I said so." I mean, to some degree I try it, but it works much better when I talk a little bit about what my concern is, or what's going on, or why I'm asking you to do something. One thing that comes to mind for me was this person that I was talking to. I've been walking around throughout Atlanta. And all the places that I normally go, I just roll up on people as I'm talking to them wherever I am and ask them, "So what do you think about this COVID vaccine?" Right? And see what they say. And the other day, I was speaking to this woman, a stranger, as we were waiting for food. And we started talking about the vaccine. And she said to me, "I don't understand why you get so sick after you get this vaccine. If you're not getting the virus itself, why do you get so sick from it?" And I told her, I said, "You know what? It's just kind of like this. It's like you got-- your immune system is just revved up, and you got all of this stuff happening with your immune system. And your immune system is like knocking and bucking and ready to fight. And when somebody is knocking and bucking, it's going to be a little ruckus."

And she started laughing. And she said, "You know what? I can see that." I said, "So you start with a little bit of knocking and bucking in your arm. But then that second one, it's like full mayhem, then it calms on down, and you're good to go." And she appreciated that. And I broke it into explaining to her that it was-- she was forming antibodies. And she had a whole immune response. And that's her body doing its job. You want to feel a little bit bad. If you feel nothing, you might be a little worried, actually. And she appreciated that. And this woman, I don't know what her level of education was. But what I do know is that we were kind of standing somewhere where she had pulled up in a car that I heard. And I heard what she was listening to on the radio. And we were in downtown Atlanta. And she knew exactly what I was talking about when I referred to that hip-hop song, right? And this is not to assume that all black people need something framed into a whole different-- in a whole different form of language. But what I will say is that our language is just fine. It is just fine. You can talk to me in a way that, that is my first language, which for me is African-American vernacular. And you can speak in references to the culture, as we like to call it. And that is not to me shucking and jiving. It is not. What that is, is saying, "Hey. You know what? Our culture is culture, too. And it is fine. And you know what? Let's just talk about this thing in a way that we-- in the ways that we feel most comfortable." And I think that's something...
that-- that's where racial concordance comes in as an important piece for this work being done. Because it will not work, right, if you show up, and you start talking about [inaudible], and you've never heard that song in your whole life. And you ain't been in a party where you've knocked and bucked before. That won't work. So it has to also be authentic. I think that's another big piece.

LN: 21:39

Absolutely. Well, I'm so thankful for these beautiful reflections, and these powerful reflections that you all have shared. And I 100% agree. I think that there's been such a focus on, "Well, look what happened during Tuskegee." Right? And as Dr. Manning has said, that's not even the right language to be using. But we're so focused on that one thing that happened in the past. And it's kind of like, "Oh. But the medical institution is better now. We don't do that anymore." But black folks know that that's not true because every single day we know what we feel in this society. And I think that also everyone's so ready to get back to normal, but the normal was never right for us. So once we get that herd immunity, are we going to continue to not make sure that we have access to healthcare, and that our kids are going to schools where they're supported and have the things that they need? And I think that those are the things that folks are thinking about. And it's not as simple as, they're hesitant. It's like, "Yeah. Well, we might be hesitant, but we got reason to be hesitant. You all are going to answer our questions before we go and get the shot." And I think that that's where you all are really speaking to. And I'm so thankful that you spoke about that so beautifully.

KM: 22:42

LaSh, can I mention one thing about-- this term hesitant is so interesting because, for whatever reason-- I don't have a better word. I don't love it. I know a lot of us feel that way.

GCS: 22:55

I'm so glad you said that.

KM: 22:57

Yeah. I don't love it. I don't love it.

GCS: 22:58

And I keep--

KM: 23:00

Yeah. It goes back to what you said about it sort of assigns blame, right? And it makes it seem like you're wrong. But that is why this whole idea of exploring people's individual reasons why, it lets you know that hesitant is probably too generic of a word to describe what people feel. My husband called it a slow yes. He said, "There's a lot of people out there. There are a slow yes." You doctors, your frontline people, you're a fast yes. But people are showing up, expecting you to buy the car on the lot right then and right there. And I don't know about you, but I have never bought a car on the lot the moment I saw it. I looked at it. I test drove it, and I thought about it. And then I came back. I do that with a house or anything. And I think that us slowing down and recognizing that hesitant is actually quite normal for any big decision that you are making that could greatly impact you going forward. And, Giselle, I wonder if you have a better word for it. It's almost like vaccine decisions. And your decision is your decision, and maybe you are a slow yes. Maybe you are a fast yes. Maybe you're a hard no. Maybe you're a I don't know. Maybe you are I'm praying on it. But hesitant, it's not enough for me. I need something meatier.
Like deliberation.

Oh. Come on. Deliberations. I like that. I like deliberations.

It's like I haven't quite decided yet. To me, it just makes-- I mean, this is not an inconsequential decision, right? This is not like buying a new pair of shoes. This is taking something into your body twice, right? You got to come back for it. You know you're going to feel bad because everybody feels bad. And they've got to monitor you for at least 15 minutes afterwards because, "Oh, by the way, crazy stuff might happen. And so we've got to watch you." Now, that to me, that's a huge decision. It took me a minute to think about it, and to really understand, "Well, why was I holding back, honestly?" And what was it all wrapped up in?

There was someone I talked to who said something so elegant. She said to me, "It feels like if you're afraid of heights, and you've looked over the edge of something. And you know are not going to fall to your death. You know you aren't. But something tells you to back up as fast as you can. And you feel something inside of you that is so afraid that you just don't want to get close, even though you know it's irrational to think. Surely, they've set up the Grand Canyon so that the majority of the folk who go check it out aren't going to fall. But for some people--" she said, "That's how I feel about this vaccine." And I thought that was perfect because there are also a lot of people who we are putting in that hesitant bucket who feel something so complicated that they can't even put their finger on it, much like being afraid of heights, to the point that it is disabling. And I don't think I'm going to die, but how do I know I'm not going to be the one person that everything-- the guardrail falls loose on, and I go falling down. I just might be the one. And if your lived experience as a black American or somebody from a historically marginalized group has involved very clear instances of you being unlucky, of you being asked to pull over, get out of your car, and get on your knees on a major street, which happened to my husband right in Atlanta, Georgia. That's unlucky. That's really unlucky. But if you've been unlucky a few times, after a while, you start thinking, "You know what? Maybe I'm unlucky. Maybe I need to look at this in the context of all of my lived experiences. And it might not be that crazy for me to think that the rail might break, and I might fall."

Or maybe I need to see a couple million people go through this.

Word.

Maybe I just need to hit the pause and hear what the science says. Because as my brother said, "Why all of a sudden we're the ones that need to be up in front, after all this time?" This was back last, I guess, sometime in the summer, where they were talking about equitable distribution and having black and brown folks being at the top of that list. And he's like, "All of a sudden, we are the ones supposed to be in front. When has that ever happened?"

And the hard part is that there's urgency. So we're kind of--
Dr. Corbie-Smith, you've been doing research, an incredible research on mistrust in different communities for a long time. But as I was looking at some of the literature in preparation for this episode on vaccination disparities and different things, I am kind of struck on how "mistrust" is often proposed as an explanation, even when it's not fully investigated, as if it's this standard default explanation that can be assumed to be the culprit, even when you're not asking specific questions that measure that. This is something that we're kind of getting into. It's the systemic issues. It's so much more than just these individual behaviors. And my question sort of is, how do we be exact and accurate about the problems that are at hand without washing them up to this generalization where it gets diluted? I think something we've mentioned is that black people are not homogenous. They're not a monolith. And when it comes to trust around vaccines, there's stratification. There's different results based on age, concerns about geography, healthcare access, income, gender, education. So how do we keep an eye on mistrust without making this assumption, making the mistake of assuming that it's always at play, especially when social inequalities can be solved? But when you say something like, "Oh, clinician mistrust," a lot of people throw up their hands and say, "Oh. Well, then there's nothing that I can do. I wasn't involved with that. That's kind of on them." How do we kind of hold both at the same time?

Yeah. I think that's a great question, Jenny. And for me, this is about interrogating the assumption that scientists are somehow objective, right? This is the need for, if you're really going to be doing this work, and you feel like your purpose in doing health equity work is to really advance equity, then it really requires that you, as an investigator, as a clinician, as an educator, take a moment, a moment and several moments, to really reflect on sort of your motivations, the frameworks that you bring to this work, how are you centering the experiences of black and brown people in the work that you're doing? What internal work have you done? We often talk about our white colleagues needing to do that internal work. But all of us, all of us on this podcast today have been trained in a majority culture. And we will internalize an oppressive stance. The fact that we're still doing research that compares what white folks think to black folks think in a deficit model, and not looking at within group differences to try to explore, tease apart, and understand the heterogeneity that you so aptly described. So to me, that's the foundational kind of work that needs to happen, is realizing and understanding the fact that all of us bring our lens to this work. And all of us have been trained in a majority culture by virtue of the fact that we're in medicine. We went through medical school, regardless of where you went through medical school. It's based on a curriculum that's steeped in a majority culture.

And you have to be vigilant and take that time to really do the internal work, to really explore theories that go outside, that are outside of sort of the theoretical framings that we have grown up
learning about, centering the work of black and brown scholars, and realizing that, when you step out there and do some of that work, it may not end up in the high-profile journals or published it because it's going to be bucking right up against a deeply personal set of value systems that are held within the academy. And I remember, I was actually-- somebody was asking me to send them a paper recently. And sometimes, I forget about what I've written. So I read it recently, this paper about sort of closing this loop between minority participation research and health equity. And I had sent that to a high-profile journal. It ended up getting published in a reputable journal. But the critiques that I got back were so personal. This was not about the science. This was about the fact that I struck a chord in someone's point of view and the way that they viewed themselves as scientists. And at first, I was deeply offended by the review. And then I was like, "Oh. All right. Well, maybe this is exactly where I need to be." And sent it someplace else that took it. So it's when you get that-- you will get that pushback, believe me, because these bands of oppression are strong and deep. And even though we're in this moment where they're flexible, they will snap back in medicine, as we've seen before. And so you have to be willing to withstand that and realize that this work, it may take 20 years for somebody to actually care about mistrust, right? But it was what was needed to be said at that moment in time.

I wanted to lean into that, Gisselle, because you and I have been talking about this for a little bit now. And you mentioned centering the work of black scholars. And yet somehow, your papers from 2002, like the OG work, has not been cited in this space because I think our community in academia is just way too quick to forget. And so you and your team published this paper back in 2002 in one of the JAMA journals asking black and white patients about how trust impacts, whether they are involved or engaged in research. And you asked these hard questions like, "Do you feel like you are a guinea pig related to research? How often, if ever, do you think your physician prescribes a medication as a way of experimenting on people? "And you saw back then that black patients were less comfortable, less trusting in this work, again over 20 years ago. And like you said, it's taken a long time for this to take off, especially in the research field. And so I wanted to get your perspective as a researcher, like many of our listeners are. How should we be thinking about this issue of trust? Like Jenny mentioned, should we be adding it to our research variables? Should we, even our study design period, be thinking about it? A lot of us are engaged in research. We invite our patients to get involved. We lead research ourselves. So just thinking again, how do you capture trust in your work?

So you look back at some of these papers, and you realize that you've changed a lot, also, in that time. I'm grateful that anybody's found any use for that work. I feel that mistrust, as Jenny has suggested, is often sort of thrown as this blanket sort of explanation when it comes to inequalities that we see in our healthcare system. But the reality is, as we've said before, coming full circle, is that often it's a blanket that sort of absolves people from actually looking at the deeper structures and practices that lead people to be mistrustful,
and also tends to obscure those relationships that Kimberly was
describing, that actually because we're not looking within group, and
we're not really trying to understand where trust is built, how trust,
it's not given, it's earned, right? This is something that we earn as
clinicians. Nobody in their right mind is just going around trusting
folks. Now, the length of time, the depth of the relationship, is
certainly going to be modified by the urgency of the issue, right? So
what we've seen in HIV and in cancer back in the days when HIV
wasn't a chronic condition, when people are facing sort of critical life
decisions, we move faster to that moment of trust. You make that
assessment. But without that sense of urgency, particularly if folks
are home wearing their masks, doing the things that we tell them to
do, well, this idea of sort of this longer deliberation-- I love, Kimberly,
your husband's suggestion of the slow yes. Like, "I'll get it." That's on
our group chat, on our family. They're like, "Yeah. I'll get it." I sent my
screenshot. My parents got it. My sister got it. But the rest of the
folks are sort of like, "I'm going to wait this out a little bit longer. Let
me just see what's going down." But the other thing about trust and
this blanket explanation of trust is that it really is, again, this element
of the majority culture focused on individuals, this idea of
individualism, without looking at systems. It's again, another
symptom of a much larger set of issues, I think, in
medicine and research, where we're not willing to look at the structural drivers of
so much of what we see that brings our patients to these
conclusions.

I think one of the things I'm excited about, about this time that we're
in, is that it's shedding a light on how much of a privilege it is to be
individual. I mean, for anybody who is black that has ever been
somewhere where they saw somebody black doing something
unsavory, if you will, the first thing you thought was-- you felt
personally like it was you, too. That they were making you look bad. I
remember students who've come up on the ward who-- maybe if a
student isn't prepared who looks like me, I take that personally. It's,
"If you don't look good, I don't look good. You're me. We're one."
And sometimes, that's good for very positive things. But sometimes,
that's a lot of pressure, to not be able to be an individual. And I think
that historically, in this country, that is really one of the areas that
has shortchanged black and brown people, that we don't get to be
individuals. If you're black, and you say no, then it's because
somewhere along the way you heard about this untreated syphilis
study, not to mention the fact that a whole bunch of people of the
current generation of people, that the literature tells us under
60-year-olds are the ones most likely to say no, those folks ain't
talking about that study in Macon County, Alabama. Half of those
folks haven't even heard of that study in Macon County, Alabama.

But we just always have this tendency to group us, whether we're
voting, we're a block. Whether we say no, we're a block. Whereas, if
one individual person-- as Isabel Wilkerson calls it, the dominant
cast, says something or does something, they get to be an individual.
And I say for the good, the bad, and the ugly, let us all be individuals.
That's going to take more time and work. And in the context of us as
individuals, as you work with me individually, you also at the same
time have to work on structures too, right? I really enjoyed in one of your former episodes of the antiracism podcast series where Camara Jones was really talking about this idea of disrupting this ideology of people believing that one person's value is greater than the other. But at the same time, the most urgent thing is to also work on the structures. Because you can't just get people to feel kind towards you and warm and fuzzy if the structure is still jacked up. And I think we have to do both. Work on the structure. But for somebody who's listening to this podcast that wants to know, by themselves, right now what they can do, let the person in front of you be an individual. As we look at each other in this group here right now, there are more of us that are black in this group right now talking than not. And I happen to know how incredibly different our paths are to the United States, just out of this group. And I think that that's part of that individualism that we need to afford people instead of just assuming that one size fits all. We're not a monolith, as you said, Jenny.

GCS: 40:55

It goes back to sort of this ideal of-- at least my hope in the work that all of us do, is to bring forth that humanity, right, for people to see the humanity in the communities that are, "hard to reach," which frankly, is just BS. It's hardly reached, right? It's like people aren't even trying. So it's this vaccine hesitancy. Well, really, it's the humanity behind that. What is it? What are those lived experiences? Yeah. And the challenge for scholars of color is that you get cut by that sort of individualism both ways, right? Sort of ascribe to one group for that one person that might have had a challenging day. And then there's the exceptionalism. Well, you're so articulate. That exceptionalism, you get cut by that on the other side, as well. So it's being able to sort of, once we get to that point where we're sort of valuing, there is not that hierarchy of human value, then-- we'll just basically have to keep treading water, in terms of advancing equity.

KM: 42:14

Oh, word.

LN: 42:16

100%. 100%. And as you all talk about this very important idea that black people are not a monolith, I'm thinking about my own experience as-- we just got funded for a grant project called We Got US. And it's all about black medical students, pre-health students in the community trying to talk to our community members about the vaccine. And something that I've realized is a lot of these types of outreach projects have really focused on black churches. But they haven't really been focusing on, what about people working in hospitals who are black, who also don't want to get the vaccine? Or what about black medical students? Even as we were recruiting, there were black medical students like, "Hold up. I've got questions, too." So I think that that is going to be really important in understanding that all of us are going to be in different spaces. And once again, you can't just treat us as just this big group, but really making sure that you recognize and acknowledge our individualism. And, Dr. Manning, I know that representation is something that is extremely important to you. And I know that you've been very vocal about your participation in the Moderna vaccine trial. So I'm wondering why you decided to make that decision and be so open about that process for you, and what that's been like for you.
Well, I think the first thing I'll say is that it comes down to who I am. And who I am is a descendant of US chattel slavery. And that's relevant because people who look like me, particularly women who look like me, they were not afforded the human right of the ability to be informed first, and then be afforded the chance to consent or refuse. And I was born into a time such as this. And I'm fortunate to be able to do that. And so to honor my ancestors, that's one piece of it. And this time that I'm fortunate to be in, I said I will go, and I will be informed. And then I will decide whether I consent or I refuse. And I'm being clear about that because we often talk about informed consent, but not informed refusal. So I like to always say get informed, and then you can choose to consent or to refuse. The next thing, too, is that I was trying to look at the long game here. And the long game is, as I'm talking to individual people and my patients and people that I work with, it has been really helpful to let them know that I know for sure that somebody black was in the study because I was in the study. That's a lot easier than telling you hypothetically that there were black people in the study. No, this person that you are talking to right now was enrolled in the study. The other thing that all of us experience too as academics is that we've all looked at a paper and tried to take that data and apply it to our patient population. And if you work in a safety net hospital like Grady Hospital, where I work, I've certainly read my share of papers where I'm like, "Well, this really is not representative of the patients that I see. But I'm going to go ahead and try to apply this data to my patients."

And I knew that it was critically important to these hardworking principal investigators and folks trying to gather this data, to have data on the people who have been the most disproportionately impacted by this disease. We needed to have some black people enrolled in the study. And it's one thing for me to say we need it, and another thing to do it. And so it's been a real religious experience, if you will, to go through it. I have a new respect for every single patient who's ever agreed to be a part of a clinical trial. It is extremely time-consuming. It is a big commitment. And knowing that, when that emergency use authorization came through for Moderna, I kind of poked my chest out and beat my chest a little and said, "I was a part of that." Part of the reason why you have that information is because I sat in that clinic, that vaccine clinic, for three and a half, four hours, several times in a row. And that is a really nice place to be. But our ancestors did not have that choice. And it was always their right to be able to say yes, or say no. But because they could not do that, I feel like, "I'm strapping you on my back. And I'm holding you in my heart. And I'm remembering everything you went through. I'm remembering your loved ones standing vigil next to your grave so that nobody would dig it up and take it over to a medical school to dissect it. I'm remembering you screaming and crying as someone decides to operate on you with barely anything. I'm remembering all of that and saying, 'I remember that this happened, but we're at the table now. I'll ask the questions that you should have been afforded the chance to ask.' And after I make my decision, just as you should have been afforded the chance to, I will
make an individual decision to consent or refuse." I chose to consent.

I think on that point, both of you are two women of color doing an incredible amount of advocacy, kind of taking this upon yourself. It's clear that your energy and motivation is so brilliant. But there's a lot of labor to be done for the inequities that we see on behalf of people who are suffering because of white supremacy. So many of these questions that we have about medical mistrust or what should we do, what's the next step, they're directed to providers of color or people of color, as if that's their responsibility. And I think that can be really wonderful, but also a frustrating part of the minority tax. I think it's something that everybody on this podcast has experienced. So what can we, or what should we expect from non-white providers and citizens? How can they best contribute to this work while still respecting the leadership and guidance of people of color and communities according to CDPR principles that both of you have really discussed? Every time I think about mistrust, I told the team earlier, I think of that song by Drake and Rihanna where Drake says, "I'm dealing with a heart that I didn't break." And I think it's easy for people to assume that to say, "Well, it wasn't my fault. I wasn't in touch with any of those things." And that's not true. So what can medical systems do to earn back the trust that they violated?

Big sis, I'm going to let you start with that.

I'm just trying to understand how deep are we really going today?

Yeah. Exactly. All the way. Get [inaudible] out.

The reality is, this culture that we all practice in is really not of our making, right? This is a white-- as you point out, Jenny, a white supremacist culture. And if you look at sort of the markers of a white supremacist culture, this is what medicine is. And it's going to-- black and brown people are here. We're here to be sort of scholar-activists in the space. But we didn't create this system. And so it's completely out of-- it's completely irresponsible to think that we're going to be the ones to fix the system and to create a system, that we're solely by ourselves going to take on this burden. White folks need to step up. They need to step up and do the work. They need to do the internal work that just as we-- the rest of us that have grown up in this majority culture and internalized some of these oppressive stances, they need to also step up and do that work to really understand and be willing to be uncomfortable. Because for us to actually have equitable systems, things will have to change dramatically. Power and privilege will have to be shared. And so what does that look like? How uncomfortable are people willing to be? Having just the lovely statement on a website, frankly, is just not enough. I'm not that interested in changing hearts and minds. I'm interested in seeing behavior change, right?

My belief is that, and you sort of act yourself into the right attitude. And that's what I want to see, changes in policies and practices and the norms that those that are in power are going to have to make those changes. I can't always be the person knocking at the door. Sometimes, I actually get a seat at the table. But after a while, just as
you said, it gets a little exhausting. Kimberly and I talked on my podcast about the exhaustion that comes from constantly laboring under this. And I imagine all of you all know incredibly well over these last 10 months how exhausting it’s been for each of you. And being sort of called on to do this work, standing up a podcast in the midst of your clinical training or the beginning of your junior faculty, things that nobody else is expected to do, shining light, taking the time on a Sunday afternoon to have these kinds of conversations, then ruminating about it afterwards, and thinking about it afterwards, and wondering what more can you do, when you really should just be focused on your clinical training, just like your white colleagues sitting in the class next to you or on service or that’s on call with you the next day. I mean, this is the sort of energy that—this is the allostatic load that we bear. And it’s completely unrealistic and irresponsible to expect black and brown people to constantly bear this, to bear this burden, and expect us to fix the system that we didn’t even devise.

But it’s such a double-edged sword, though, right? Because when I see someone not have enough cultural humility to ask the questions that need to be asked, and I don’t know if that’s because of indifference, or if it’s because they are so warm and fuzzy and caring toward me and my wellness that they don’t want to tax me further. I’m just giving you the benefit of the doubt, that when I see that—

You’re a better woman. That’s when I know you’re a better woman than me.

Right. Right.

Right there.

When I see something like that, I think to myself, “Did you talk to anybody black about this? You should have asked me. You should have spoken to me about it.” But, at the same time, maybe people don’t want to ask the questions, or they’re nervous, or they’re scared or whatever. One of the personal struggles that I have, I have not found the answer to this yet, at all. But I’m trying to find the space where I allow you to approach me to ask that thing that you just don’t know, and you won’t know because of your lived experience. But at the same time, finding the space to protect my wellness. And that’s where it’s important for me to be surrounded by mentors and sponsors and coaches and people who care about me, so that I can ring up Gisselle and be like, “Look. What you think about this?” Or have her model for me what no looks like to protect myself from certain things. But there will be other times where it’s too important for me to not step into it. Because the thing about the minority tax—and this is just my thinking about it. I say that my taxation is not without representation. My taxation is not without representation. And what that means to me is, when I look at my face in the mirror, and I see the smattering of freckles on my nose, and I see these slightly Eurocentric features on my face, I know somebody in my family got violated. And what that means is that every single opportunity that I get to go hard for my people so that they are not violated, as is reflected in my own reflection— I have evidence that
my loved ones, that my ancestors were violated just because of how I look. I know it, right? It makes me go harder.

I'm like, "Man, you know what? Let me take a nap. Let me go for a run. Let me go have brunch with my girlfriends. Let me go hang out with my sorority sisters. And let me get back at it." But figuring out what other things for me to do, and what are the things where you're just trying to text me and use me, that's the space that I don't really know the answers to yet. And I just want to go back to one of the things you said, Gisselle, about this idea, as we think about this all being built on white supremacy. A lot of people-- I would say that a lot of people who are listening here who are not people from marginalized groups that are wondering what they can do, they really do have to do that work of, what will it look like when the musical chairs, where the music always stopped, and you had a seat? What will you do when the music stops, and I sit down, and not you? Because somebody has got to give up a seat. Somebody is not going to sit. And I think that it's fine, as long as the music is playing, and we're walking in the little circle. They are happy. Everybody is giddy, like, "Woohoo. Let's do this. Take a knee. Black lives matter." But the minute they shut that music off, and it's time to sit down as the chair of the department, the dean, the president of the SGIM, or whatever you're going to do in a leadership role, that is when it ain't funny anymore. That is when you get those reviews like Gisselle got when she sent that paper in. Because this is all fun and games until somebody has got to give something up. And if everything has been built on privilege, you have to be willing to give something up. You want to know what you can do? You can do the work. You can check your biases, but you can be willing to give something up.


Yeah. I mean, you left us speechless. Yeah. You left us speechless, Kimberly, right?


Yeah. I had this conversation with somebody once where they were talking about how-- it was like in some national platform or one of these many [inaudible] where somebody was talking about how there are people who historically got a lot of interview offers for residency who aren't getting as many anymore. And some of it is probably related to programs pushing their DEI efforts and trying to find the happy medium. And I was like, "Wow. You wrote that right out in the open."

Like for everybody to see.

No. So here's the thing. it's just that now-- like now, that they're considering people, they're broadening it, basically making it sound like, "There are people who don't really deserve to be there as much, but because of these quotas, they're letting them in and taking your spot." Where another way to look at it could have been, "These people who were always deserving, who were always qualified, who could have always been at the table with you and awesome, now we see them." And guess what? Musical chairs, [inaudible]. It's only so
many chairs. And the music got shut off. And you used to always get a seat, but this time, you’re going to have to go somewhere else.

GCS: 58:12
It's the fallacy of the meritocracy, right? And they always will trot that out.

KM: 58:16
Things sound better when you say it, Gisselle. That's what I meant to say, you all. It's the fallacy of the meritocracy. That's what I meant to say. That's all.

GCS: 58:26
They'll always trot that out, right? They'll always trot out that argument, as if in some way, coming from a different background, having an experience that's different than yours is at odds with excellence. And it's like, in fact, if you actually want excellence, you need to make sure you're pulling from all the best and the brightest brains across all of the different ways that they make-- the bodies that those brains may be in. It just drives me nuts. "Well, all we want is the very best." When you start talking that BS, that's when I know that you're not committed.

UE: 59:09
I love it. You all, I mean, that musical chair metaphor slapped. Gisselle, you shouted out your podcast, Different Kind of Leader. Go check that on Apple and Spotify. But I think that really segues us into our second to last question on the pod, which is just that. What should leaders in this academic medical space, leaders in the political space, and policymakers, what should they be thinking about as we realize that black and brown individuals are the least to be vaccinated right now? As we think about opening up the vaccine to broader communities beyond healthcare workers, beyond the very elderly, what should they be doing while we on this podcast, we as learners, we as trainees, take on some of these more grassroots efforts? And I'll start with you, Gisselle.

GCS: 59:57
So, I mean, when you're looking at racial disparities, you need sort of race-targeted interventions to address those disparities, right? I think addressing and meeting people where they are is critically important, as Kimberly has already said, being willing to have that conversation on a one on one context, and backing that up with systems that are going to support equity, not equality, not this fallacy of equality, where we have an open system that everyone, theoretically, everyone should be able to sign on to and get a vaccine. At least in North Carolina, that's what our system looks like. But what we've seen is that there's-- this pandemic has shown us this fault line between public health and medicine. And we need the folks that are actually able to cross that bridge. So we have community-based organizations, faith-based organizations that have been in that breach right now and for the last almost year, filling that breach and have been doing it beforehand. How are we supporting and ensuring that those organizations are part of this relief effort, part of this distribution effort, and will be supported going forward? Because many of them are sort of hanging by a thread. So many practices in black and brown communities are actually shuttering because of the impact of this on their economic bottom line. We need to think about community health workers that can find people and put them into those slots, that even if it's the slow yes, so that they can get that information, and they can be assured of a place.
We have to think about geographic focus. If we're standing up clinics and clinical sites to provide vaccines, we need to ensure that the people in those communities, in those zip codes are the ones that have preference of getting those vaccines. There's a reason if you're putting it in a poor black or brown community, that those individuals need to have priority. I'm not saying that we should be wasting vaccines. If we have extra, bring in other folks. But it shouldn't be a system that people in my community who are upper SES are able to go online and go an hour and a half away, go across the county line, and take a slot that should be for the elders and for people with multiple chronic conditions. It just shouldn't be. So that's where I'd start. And we need to stop having mistrust as a scapegoat, frankly.

KM: 01:02:29

Co-sign big time. I would also add, I mean-- and really, I'm just more reiterating what you said. And that is just this idea of meeting people where they are and looking at what are the barriers that this system has created that have made it hard for people to get vaccinated, right? So for those of us who have gone to volunteer and vaccinate people, you see this thrown into relief. It takes an act of Congress, really, for you to fill out the form. You'd better be literate. You'd better have good vision, and you'd better have the right reading glasses, if you're reading-- if your vision is poor. You'd better have the dexterity to write on that paper. You'd better have ID. You'd better have somebody to bring you up there. You'd better have legs that can stand in line for a long time. You'd better have a coat because you might be standing outside. All of these things that I think stand in the way of making it difficult for people, I think we have to move those things out of the way. The thing also about the slow yes people is that when a slow yes person gets to the yes, that yes can be a little unstable. And I think that we have to be ready to vaccinate people when the slow yes moves into a yes. And vaccinate you right now. And I don't know what the data says about once you get a first dose, whether or not you remain hesitant. I have a feeling, my own hypothesis would be, once you got your first dose of the vaccine, that kind of broke the seal on it for you. And you are probably game to get your second one. But I think that there are instances where we have to make it easier.

KM: 01:04:10

So concretely, we need to have people standing out at these places when our elders show up, just like we do when we're doing voter registration, who can type everything into the computer for you, who can fill out the form for you, to afford you the chance to make your mark if you are a person who is not comfortable writing or reading, all of these things to make it a little bit easier to people. Take all of this tech-savvy requirement out because there are folks who are just going to give up because they're not tech-savvy enough. And then I think just coming into the communities, like Gisselle was saying, it's going to be important, as well. Why can't we have somebody vaccinating people up in the barbershop, in the hair salon, at a megachurch, at the senior center, and doing it sort of right now, not where you have to sign up 500 years in advance and put down your great grandbabies future Social Security number. Some of these things are just too difficult. And for those of us whose parents are older, we've all tried to get our parents vaccinated. And it is really
difficult. I had three screens open with three websites open at the same time trying to get my mom vaccinated and my dad vaccinated out on the West Coast. And it was very, very difficult. And I’m finding that what’s happening, though, is that people are looking for workarounds. So the same thing that you were just talking about Gisselle, it’s so hard. You know that ethically, the right thing to do is to try as hard as you can to get the person vaccinated in the county where they live. But when none of that works, and you start to get anxious, you start being like, “Okay. Well, let me look two counties away. Let me look three counties away, four counties away.” And then you end up praying upon the place where people are still not sure if they’re going to say yes or no, but they have the spaces. So you get down there, and this is filled up with all of these people who are higher socioeconomic status, non-black folks, non-brown folks, down in the hood getting vaccinated. So something’s got to give. We have to have it be a little bit easier so that when a person’s ready, that we’re ready to vaccinate you.

Well, I’m still just trying to reflect and marinate on all of the knowledge and wisdom that was just dropped in this past hour. And you all took it from a conversation about how it’s more than just Tuskegee, and how we need to make sure that we are framing the true context around that story, and that we’re honoring our ancestors in that way, as well. We also talked about how it’s not hesitation, but it’s deliberation. We need to make sure that we think about the way that we’re framing that, as well. We talked about musical chairs, and how it’s a big party until there’s a conversation about who is going to actually take the seat at the table and be represented. And we also talked about how this is a systems-level issue that we need to be discussing. And it’s more than just this individual medical mandate to get people to take this vaccine. But where are the structures that we need to re-inform and think about? And how that impacts the health of our folk’s lives, and so much more. And we’re just so thankful that we have these amazing guests on our show. And we ask you to just please continue to uplift their work, listen to their podcasts, follow them on Twitter, and please take their advice to heart because that is the only way that we’re going to truly be able to promote health, equity, and justice in our society, and to continue to improve the structure that continue to oppose systems of oppression right in our lives. So thank you all so much for everything. And we hope that you enjoyed this as much as we did.

This was so great. Thank you.

We’re so proud of you all. And thank you for all the work that you’re doing. It’s not lost on us. And we are learning right along with everyone else. So thank you for pouring into us. This is the kind of work and the kind of effort that helps us to keep running this race. And when we say our taxation is not without representation, know that we are the pipeline. We are all the pipeline. And seeing you do this work, that is a part of who we represent, as well. So I’m just so grateful. So thank you.
So amazing to have this kind of space. It's, well now, an hour-plus out of our weekends. I couldn't think of a better topic and a better set of people to actually spend this weekend afternoon with. So thank you so much. It's really generative, enriching, and sending me off into a great week. I'm sure.

I'm going to say the fallacy of meritocracy this week, somehow, for some reason. And I--

Listen.

And I'm not going to give you credit. I'm going to act like I-- I'm just going to act like [laughter].