

## Prioritizing Equity video series: Trustworthiness & Vaccines

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The AMA's Prioritizing Equity series webinar on Dec. 10, 2020, explores misinformation, trustworthiness and strategies to handle vaccine hesitancy among patients and health care professionals.

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### Panel

- **Marcella Nunez-Smith, MD, MHS**, Founding Director of the Equity Research and Innovation Center (ERIC) & Associate Professor of General Internal Medicine, Public Health, and Management at Yale School of Medicine; Twitter: @ERIC\_Yale
- **Giselle Corbie-Smith, MD, MSc**, Chapel Hill Director of the UNC Center for Health Equity Research, Kenan Distinguished Professor of Social Medicine and Medicine at the School of Medicine; Twitter: @gcsmd, @uncCHER
- **Margaret P. Moss, PhD, JD, RN, FAAN**, Hidatsa/Dakhóta, Director of the First Nations House of Learning and an Associate Professor in the School of Nursing at University of British Columbia; Twitter: @mpm40
- **Lauren Smith, MD, MPH**, Chief Health Equity and Strategy Officer for the CDC Foundation; Twitter: @CDCFound
- **Kim Gallon, PhD**, Associate Professor of History at Purdue University and founder and executive director of COVID Black; Twitter: @COVIDBLK

### Moderator

- **Aletha Maybank, MD, MPH**, Chief Health Equity Officer, Group Vice President, Center for Health Equity, American Medical Association; Twitter: @DrAlethaMaybank

## Transcript

Dec. 10, 2020

**Dr. Maybank:** Good afternoon, everyone. I am Dr. Aletha Maybank, chief health equity officer at the American Medical Association. And I thank you for joining us for this next episode of Prioritizing Equity. We have a really important conversation as many conversations have been important over the last I'd say months, I guess, but especially now more recently as conversations around the pending approval and distribution of COVID vaccines are continuing to heat up and there are growing concerns over distress amongst people impacting the uptake of the vaccine. And we know that distrust is rooted and exacerbated and really made worse by the lack of trustworthiness by institutions and government, just to name a few that we know exist. I wanted to be very clear as I start off by saying that, patients and communities have a right to distrust health communities, health officials. It is a really rational place for them to come from especially for Black and Brown communities.

There are well-documented harms both in stories that have been passed down across generations and in the present lived experience, and there's growing scientific evidence that tells us our systems and culture of health and medicine are impacted by racism. I also think it's important for me to also add that I will be ready to take the vaccine when it's FDA approved and considered safe and effective. However, I do acknowledge my privilege and power in being able to make that decision. Not only do I constantly have access to the information and the experts, but I have the ability to understand the science. I went to med school for that. And so, our conversation today on vaccines will really cover misinformation and strategies to address distrust and hesitancy. So today, we have like a truly powerful panel of folks I have admired from afar and for a while. We have Dr. Giselle Corbie-Smith, from UNC at Chapel Hill, director of UNC Center for Health Equity Research and distinguished professor of the School of Social Medicine and the School of Medicine itself. Do you mind just waving your hand real quick in case they can't see your name?

Dr. Margaret Moss, who is director of First Nations House of Learning and the associate professor of the School of Nursing at the University of British, Columbia. We have Dr. Lauren Smith, who is chief equity health and strategy officer at the CDC Foundation. Dr. Kim Gallon, who is associate professor of history at Purdue University, and founder and executive director of COVID Black. And we will be having Dr. Marcella Nunez-Smith, who is founding director of the Equity Research and Innovation Center at Yale, and also now on the transition team and part of the leadership of the COVID equity task force currently. So she has a new position, new role in federal government that's very busy. So she's going to try to join us a little later in the conversation, but let's get started. And we'll get started in the style that we always do at Prioritizing Equity. I just want you all, first, to just go around and say where you are, literally right now, geographically and how are you doing at this point in time of our COVID-19 pandemic. So Dr. Gallon, can we start with you?

**Dr. Gallon:** Sure. So I am zooming in from West Lafayette, Indiana, where Purdue University is and it's a pretty sunny and bright day here, but where I am in terms of the pandemic is where I kind of started, where I'm going from sort of these highs and lows. Highs, because I'm engaged in probably some of the most important work that I've ever been in my professional life but lows because we are still in the midst of the pandemic. And I was just telling my daughter who is 14, trying to help her understand that with the vaccines, we're at the beginning of the end of the pandemic, hopefully, but at the same time it looks as though it's going to get worse before it gets better. And so, it's this sort of vacillating between feeling really good about the work I'm doing but also feeling a certain level of sadness and sort of just lows because of the lack of response that we're seeing from the federal government.

**Dr. Maybank:** Thank you. Dr. Corbie-Smith.

**Dr. Corbie-Smith:** So physically I am in Chapel Hill, North Carolina, between two bedrooms and our retreat. So you might see children walking behind me, this is the reality of work from home. I feel incredibly privileged that I can do the work and just like Kim, this is some of the most impactful work that I've had the privilege of being able to do during my career. And so, I am, oh, there's one. And I am, similarly to folks that have been doing this work for a long time, I am both distressed by where we are in the pandemic, the disparities and the needless suffering and pain that folks are experiencing now across our nation, and across the world, as well as being hopeful as we're now at a point where people are truly understanding or beginning to understand and have a willingness to have a deeper appreciation for the structural nature of health inequalities. And hopeful that we'll come out on the other side of this in a space where we, actually, have both the will and the skill to be able to make true change.

**Dr. Maybank:** Thank you. Dr. Moss.

**Dr. Moss:** Sure, thank you. I would like to acknowledge that I'm coming to you from the UBC campus,

and that is on the unceded ancestral and traditional lands of the Halkomelem speaking Musqueam people here in Vancouver, BC. And I acknowledge I'm a traveler from my own nation which is, the Three Affiliated Tribes of North Dakota, the Mandan, Hidatsa and Arikara. And I have concern in every realm of my life because as teaching outgoing BSN students and sending them out into the COVID reality is one thing. I do have four children, luckily they're in their 20s so they won't be running by me at all, but they are all in different states. I'm from the U.S., just working here, and I worry about them. They are both Black and Indigenous so hitting so many things, and we are from, our home is kept in Minneapolis.

So, as you know there were so many crushing things happening; the epicenter of George Floyd, the COVID realities, the tent cities cropping up for Indigenous because there's nowhere to go. It's just one thing after another. And then just in my work, Indigenous people are often left out of the conversation unless things are just awful and you can't. So the only time you hear about Indigenous realities is because something really awful is happening and here in COVID, they are contracting at three and a half times the rate of non-Hispanic Whites. So in almost every area it's one crushing epidemic after the other, but I have hope, and I too would put forward taking the vaccine once it is deemed safe and we know what's happening and that's pretty much what I hear out there.

**Dr. Maybank:** Thank you.

**Dr. Moss:** So, thank you for this.

**Dr. Maybank:** Absolutely, thank you. Dr. Smith.

**Dr. Smith:** Yes. Hi, I am here at my home outside of Boston, which Margaret I believe, is in the conceptual lands of the Wampanoag people of eastern Massachusetts. Feeling, I don't know, it's sort of a mixture of, I won't say fatigue, but just a need for stamina. It's been a long time. I was saying to you all before that I'm a hugger and I get energy from being with people and connecting both physically and spiritually. So the separations of not being able to see friends, if you do see friends standing outside, which is fortunate, but yet not being able to sort of have that physical touch has been a little bit draining. But on the other hand, I think is, Giselle you may have mentioned, I feel blessed that our family has been safe. My three kids, I have three young adult children also, have been safe and healthy and made it through a semester of the college. I have two sophomores and so, they knock on wood, have made it through this semester so that's really good.

Work is really giving me even more meaning, I think. I started this role about eight weeks ago. So talk about a time to be thinking about this work and wow, I just feel like every day is an opportunity to really connect and do your best to make a difference. So having that opportunity feels like a blessing, to be able to do that so I'm grateful for that. And I'm feeling like you need to kind of maintain stamina. And I will be happy to get the vaccine also when it's my tier comes up, I'm sure we'll talk about the different tiering and how people are gonna prioritize the vaccine.

**Dr. Maybank:** Great. Thank you. So let's get into the mid of the conversation, and thank you all for sharing your minds but also your hearts. As I always say that's an important part of equity work and transformation work. So, we know that there's a long history of medical and scientific racism in the United States, you all have studied it, and a lack of trustworthiness as I mentioned before on the part of health care institutions. There's the politicization as well as polarization as the response to the epidemic. And we know as is already highlighted, the disproportionate impact related to Black and Brown people and getting sick as well as dying. And so, the levels of distrust for our health care systems have really only increased. And so Dr. Corbie-Smith you are one of the leading experts in research. And before I have known you personally, I've been reading your work for a long time, and you really understand the roots of distrust. And so, can you please provide a frame on how we should be thinking and applying and speaking about the history's complexities of distrust on this modern day epidemic.

**Dr. Corbie-Smith:** Thank you so much for that question. And I honestly, I'm just honored to be on this panel with this incredible group of colleagues. The work that our team did years ago around distrust highlighted the distrust in research, and really highlighted the challenges in terms of minority participation in research, and distrust around research is grounded in their experiences within the clinical context. That this is not something that's fabricated and while historical, unethical examples abound that was not always the, sort of, the narrative that people had. It's certainly part of the historical narrative and that lives within our collective consciousness in Black, Indigenous and people of color communities but it's not solely that. People typically will point to the U.S. public health service study at Tuskegee University, would prefer you to call it, since it was actually a U.S. government funded study. And they'll talk about, and I remember a quote from our early focus groups where we were talking about participation in research and this participant said, "Given the way brothers are treated in this country, how do I know that participation is going to help me in any way?"

And so, this goes to not just this historical context but also the current present day. And I'll just share what—when we're talking about research, and research findings, and these innovations around prevention, one of my community partners and many of you all probably have heard this in your own families and communities is the idea that, people will care about what we know when they know that we care. And right now, as we think about demonstrating the trustworthiness of science, the trustworthiness of medicine, we have a real opportunity to demonstrate our trustworthiness because

we haven't done it so far. We have seen over time the disparities in health that, for those of us that do this work, all of us on this panel while distrusting, there were really no surprises about what we were going to see in terms of who was at higher risk for infection, who was going to be at higher risk of morbidity and mortality. These are structural factors that tell us what we care about, right? This is what we care about in our country and we have not demonstrated that we actually care about every single person having an opportunity to have a healthy life in this country.

**Dr. Maybank:** Absolutely. Thank you. So we'll take just a quick pause. We're going to introduce Dr. Marcella Nunez-Smith. We're so glad you could join us today. And I'm going to go to Kim, ask her a question then I'm going to come back to you to just fill us in on where you are because I know you might not be able to stay on the whole time in case you get called, so I just want to make sure I come back. Dr. Gallon, I just want to continue on that because you also, through COVID Black, have learned a lot from your research, and I know you've done some research lately. So can you talk a little bit about that research, what you're learning and then we'll talk about how does that get applied?

**Dr. Gallon:** Yeah. I kind of want to pick up where Dr. Corbie-Smith talked about in terms of Tuskegee because we hear so much about Tuskegee and it's important, right? And I appreciate Tuskegee wanting to reframe the conversation about it being a U.S. government led and funded study. And I'd like to reframe the conversation too, to talk about trust and how historically Black communities have trusted Black doctors, Black institutions. So when we look at Black public health campaigns and informations, they are rooted in Black institutions like the Black press, historically Black colleges and universities. And so I think, we have a more complicated and maybe more nuanced conversation about trust, right? Where Black institutions are at the heart of campaigns, and movement, and the Black Negro Health Week that started in 1915, which starts in Tuskegee, right? So if we can reframe this notion of Tuskegee and Black health to one where we see Black doctors, and Black scientists, and Black health care providers and center them, I think we can have more complicated conversations where we are communicating to Black communities, that our history of Black health, isn't always a history of deficit and medical experimentation.

Well, that's important and we need to know that history. We need to also know another history where Black people were pioneers and innovative, sort of, producers of public health. And I'll just say one more thing is that, I think we all still have to talk about trust where we are asking White institutions, predominantly White institutions to trust Black doctors, Black researchers to implement the approaches that they historically and culturally know will work with Black communities, right? And that's going to mean giving time and resources to those Black institutions, and doctors, and health care providers so they can go into Black communities and engage in strategies that are going to be really effective.

**Dr. Maybank:** Thank you. Absolutely. So Margaret, just to continue on that thread, because I do want to just highlight, as you mentioned, the invisibility and being made invisible really because people are

there and they know we're visible to one another. Can you talk about, more so kind of, what are you considering, and what should we be considering more so in the conversation, as it relates to indigenous people in this country, as it relates to mistrust and messaging as well which is kind of being implied, what Dr. Gallon is saying, and who is messaging.

**Dr. Moss:** Okay. Thank you. I often give a talk to either my students or as I go around the country where it's actually titled "Assume Trauma," because it really has to be assumed with indigenous people and ruled out. You need to approach with cultural safety, humility, respect measures and an understanding, and that's where the gap is, that's the problem. People don't know the history and that's by design. We don't learn it in the schools. I literally, when I went to law school was going, "Oh my gosh," when I took some of the targeted courses that I had no idea myself having already received my PhD, I had no idea because I had the same education everybody else, and I grew up in an urban situation. So when I try to really make an impact, I try to tell people, "Do you realize that you can map the federal policy periods having to do with American Indians and Alaska natives," I'll say Indigenous to be inclusive, which were; relocation, reservation, assimilation, termination, it just went on and on, people. If you say those words in Indian country, they instantly know what you're talking about. If you say it anywhere else they're like "What?" If you say one of these have to do with each other, these words, nobody knows.

You can directly map those under the UN definition of genocide, directly killing members, causing bodily and mental harm. It's not just all physical, imposing measures to prevent births, along with the U.S. study at Tuskegee at the same time Indian health services is sterilizing Indian women without their knowledge or consent. All these are again, are federal program and forcibly transferring children, which was the assimilation of fostering, adopting out to Whites, which is now against the law, and the boarding school part. And people don't really—Indians instantly know all of this stuff happened and they know that there was actually genocide. Being here in Canada, they actually say genocide of Indigenous people. U.S., I don't think has come close to recognize this, but the Indigenous people here do recognize it. So therefore, yes, to mitigate this horror is just another crashing contemporaneous epidemic on top of all the historical trauma, unresolved grief, intergenerational trauma, add one more. There's murdered and missing women where Indigenous women are murdered at 10 times the rate of the next closest group on reservation because of laws from the 1800s that are still on the books. So this is just like adding another thing.

So, what should have happened is starting to build trust, acknowledging these things, we have to teach it. I also run around talking about indigenizing and de-colonizing health professions. Teaching does it, a paragraph at the end or, "Oh, Indians might think this" based on what, I don't know. But anyway, to mitigate this trust-building, culturally relevant communications—one young man who I was talking to, who's fairly traditional and again, we run the gamut. I mean, I say Indigenous American Indians but it isn't a pan-Indian thing either. You have Westernized to traditional and everything in between, but he said, "Once I get a signal from the ancestors or I hear it in my native tongue from

elders, it's okay to do this, that's when I'll do it." But unfortunately, the elders were the first group that were really picked off. And my last thing about that is that, there's only seven to eight percent of American Indian population makes it past 65 as opposed to 14, 15% of the general population. So they're being picked off right now, right and left, and if they're the ones who are going to help make it okay, then we're really in trouble again.

**Dr. Maybank:** Right. And so, thanks for all of that. And moving to, kind of, so what do we do I'm going to come to Dr. Nunez-Smith and congratulations. We are all very proud of you and just very honored to have you in roles of leadership at the national level, very important to see and center our voices in these conversations. So are you able to just speak to kind of one, how are you doing, because we started off the conversation in that way. You and I had a conversation a couple of days ago or last week, and it ended up being a therapy session, and that's how it is, but how are you doing? And then also kind of what are your expectations for this role to help support addressing this mistrust in our country?

**Dr. Nunez-Smith:** Thank you so much for having me today. I am in awe of the co-panelists, all just brilliant. And for a second there, I forgot that I was on a panel, I was just listening, and amening and nodding and everything. So much wisdom here. So thank you for asking on that personal note, how I'm doing. I think we're all maybe riding the same roller-coaster, right? I'm looking for moments of hope and optimism and light and cannot close my eyes to the reality in our faces. What's happening in our country today that yesterday—we're setting these terrible milestones over and over again with this phrase that we all can just see in our sleep, right? Disproportionate representing, disproportionate burden, disproportionate, right? It's Black and Brown lives that we're losing.

And I worry that people become numb to understanding the grief and the suffering and the loss behind each one of those lives that we lose in our country. Just to imagine what people could have done. But I feel motivated as I hear even in the voices of everyone else here that we have a lot of work to do, but we have the resolve, I think, to do it. So I also appreciate your personal note of congrats. But I think, take a step back, well first of all, it's about the work that we're all doing, we're all in this work together, and really appreciative of this forum today and recognizing the important partnership with AMA. But it's notable for our country that there is a role even that is about equity. That is a particular moment. It's not about who is in it, it's that there is a prioritization in a way we haven't seen before, not in a Pollyanna way, but maybe can give and breed some optimism.

**Dr. Maybank:** Absolutely. And do you have a sense of any kind of, because I'm going to take your time just a little bit just in case you have to hop off, but do you have a sense of some strategies that you are thinking about employing and what you've been working on and talking about with other members of the task force and other federal agencies on kind of the strategies around addressing distrust and messaging of that nature?

**Dr. Nunez-Smith:** Yeah. This is the most central conversation, right? And, sort of, with apology



joining a little bit late and got to hear some, this is where so much of our work is on the advisory board now. I mean, it has to be, and this is something that's ongoing. One of the things that I want to lift up maybe has been said is, we do say a lot about trusted messengers and who are the trusted messengers and what does that mean, but to really just kind of double down on the important role of health care providers as trusted messengers, right? So no matter who you ask, when we start this conversation of vaccine hesitancy, I like to remind everyone that we see across the board in our country questions, people have questions, right? All comers. So this isn't a phenomenon that is unique to the communities that we're talking about today or that we're representing today. Lots of people have lots of questions as they should. Everyone needs to get their questions heard and answered about things like safety, efficacy, and cost, that's everyone. And when we ask, "Who do you want to hear messages from?" The answers are quite similar. People want to hear answers about science from scientists, about health care from doctors, right?

And so, how do we make sure that health care providers have the information that they need. And I think it is important whether we talk about providers who themselves identify as a being of color, who are part from these communities. Really critical that we, I'm a practicing internal medicine doctor, so we have the information, right? I get at least five texts a day from colleagues and friends who are asking me, "Should I take this, is this safe?" And so, when we have to sort of think first of what do health care providers, our colleagues need to know so they can make an informed decision about themselves, for their own, this is everybody at the front of the line, right? So to make an informed decision about what they do, and then to be able to talk to their patients and recommend their patients. So that is our job. We need a unified message, we haven't had that around really what I think are the right questions to ask. And I appreciate you kind of opening the mic for me longer. I am with this panel until the end. So please let's share the space.

**Dr. Maybank:** Great. Thank you. Dr. Smith, I know you've been thinking about this. And what is it that providers should be saying. How best do we support those conversations with their patients? And it's not only the patients, as Dr. Nunez-Smith mentioned, it's our family, it's our friends, and sometimes things are set and landed in our laps we're like, "Oh, okay." So what is the process of, how do we go through that conversation? What should be said?

**Dr. Smith:** Well, I think it's an incredibly important conversation. And just to pick on a thread that Marcella had mentioned, around transparency and completeness and timeliness of information. I recall during H1N1 pandemic where I was at a state health department and when the vaccine became available for H1N1, and we wanted to make sure that all health care providers took it, we got a lot of pushback. There were a lot of health care providers who you would think would say, "Hey, it's been deemed safe, it's effective. I work in an intensive care unit or a cardiac care unit, clearly my patients are at risk so I would want to do it," there were a lot of health care providers who said, no. Now, interestingly, there was a union kind of situation related to that, which we can talk about separately. But I think that idea of ensuring that the providers feel like they've gotten enough information that's

transparent, it's accurate and complete so that they can, with a straight face, say what you said at the top of the hour, when it's available and deemed to be safe and effective, I will be there, doing it.

So, I think that, that's really important because we want people to be confident. And the last thing I would say is, this whole piece around trust has raised issues of agency, individual agency versus coercion. And there's a lot that I'm sure I see lots of head nodding around. Are you trying to convince someone, are you trying to persuade someone? What is the nature of the kind of conversation that providers are looking to have? This whole process of co-leadership of what the clinical interactions are going to be, and people are practicing differently now than 10, 15, 20 years ago where if the doctor or nurse said to do something, maybe people would be more likely to just accept it without question. But I do think that it's bringing up those questions about are we trying to convince, are we trying persuade, are we trying to educate. We definitely don't want to be coercing. I think that's pretty clear, but are there other elements of any of that in any of those other approaches that need solving?

**Dr. Maybank:** Absolutely.

**Dr. Corbie-Smith:** I wonder if I could jump—

**Dr. Maybank:** Yes, please.

**Dr. Corbie-Smith:** Jump in on that, because that's exactly, I mean, there were two threads that have come up that I wanted just to underscore in Margaret, Marcella's and Lauren's comments. The first is exactly what was just said that, we need to make sure everyone, both our health care professionals as well as our patients have ready access to the information that they need as well as access to the care that they need so that they can make decisions around prevention and treatment that's in accordance with their values and priorities. I think all of us are on some group texts where you're kind of like, "Oh my goodness. Wow! Okay, where did you find that on the internet?" Around coercive, what I would coercive practices or proposals around tying monetary distribution to getting access to the vaccine or getting access to money if you get the vaccine, which I think just puts us in the wrong space and just underscores why people would be distrustful of the federal government.

The other thing that I wanted to bring up that Margaret's comments just so beautifully illustrated is that, any solution has to be a structural solution because all of the heinous initiatives that have led to the death and destruction of Indigenous people through colonization to the people that have been enslaved in this country and exploited have been structural in nature, and this ties us back again to Tuskegee. This was not, sort of, the lone wolf that we typically hear about when they're, sort of, manmade acts of violence amongst communities. This was a structural deliberate—

**Dr. Smith:** Institutional.

**Dr. Corbie-Smith:** Program and an institutional initiative. And so, any interventions at this point need

to demonstrate that same intention and fidelity to structural change.

**Dr. Gallon:** Yeah, I—

**Dr. Maybank:** Can you just real quick before, I'm going to get to you, and you can chime in on this as well. I just want it for the audience because the reality is, in jumping into more of health care, and we're in the equity space. So we talk about structures, we talk about structural racism but that does not translate for everyone. So can you provide, and this is a collective view, examples of what does it mean to have a structural solution?

**Dr. Gallon:** Well, if I can just jump in, I just wanted to reiterate what Dr. Corbie-Smith was just saying about a structural approach to problems that have been structural. And just even more so say that the recent data, I think by the Kaiser Family Foundation and the COVID Collaborative, suggest that the biggest concerns for at least Black Americans are the process of developing the vaccine and the systematic, sort of, approaches to the rollout of the vaccine, right? And so, everyday Black Americans already are attuned to the fact that this is a systematic issue that has very deep, long historical roots. And I'll just add in really quickly, before I talk about what might be some ways to approach it structurally, is that, every one of my family so far, and I've just done an informal survey, have all said they are not interested in taking the vaccine at least immediately until it can be demonstrated on a systematic level and in a broad based level that the vaccine is safe. And I did have one of my closest friends from high school who said, "Oh, you're the radical Black historian, I can't believe you're going to take the vaccine. You out of everyone should be the most distrustful because you sort of know this history."

But I think when we think about structural approaches, I really do believe that there has to be sort of a structural overhaul on how health care providers of color, the resources that they're given and their own marginalization. So I'm probably the only one in the panel that doesn't have an MD but have a PhD in history, but I think that we will be missing or remiss to talk about sort of the ways that Black health care providers had their own, sort of, engagement with structural health care that leaves them often, and maybe marginal positions relative to the system and relative to their White counterparts, right? And so, I think that to have a structural approach to the structural inequities requires resources and a systematic approach that centers Black health care providers, and creates pipelines for them to create programs and strategies that are going to be centered in Black communities.

**Dr. Maybank:** Anybody else want to add to that? Dr. Moss, you're on mute.

**Dr. Moss:** Sorry about that. So, I have been harping on structural determinants of health and so forth for several years now. I know that in the health professions we rarely get there but we're lucky to get the social determinants of health, and of course the structural ones are undergirding even those ones. I use an exemplar right now because three years ago this happened, and I don't know if anybody heard of it, but I talk about, as far as structure, for instance there's Mount Rushmore for American

Indians called the Four Horsemen of the American Indian Apocalypse. Every one of them, Washington extermination, Jefferson architect of the trail of tears, Andrew Jackson carried it out, Theodore Roosevelt saying the only good ones are dead Indian and that kind of thing, that's 200 years of presidents. And then Lincoln, who is so revered, but not by Indians, because he ordered the largest execution on U.S. grounds the day after Christmas in 1862. And it was called the Dakota 38+2. Gallows big enough to hang 40 people without any trial or five minute trial, people couldn't even speak English, and they just hung them to get the land to the Minnesotans.

Nobody knows this and this was seven generations ago, which is a big concept thread across Indian country. So fast forward seven generations, three years ago on 2017 what was called the Walker Art Museum in the Twin Cities in Minnesota again, authorized a White artist, two of them actually, to replicate these gallows big enough to hang 40 American Indians. They didn't consult with any American Indians, they didn't consult with any elders, nothing, and they just went ahead and did it. Did it hit any of the news at all? No. And in the same week somebody had written disparaging remark on, I don't know, LeBron's garage and single noose was found at the new African-American museum of Smithsonian. Here's the gallows, and I have pictures of it, is big enough for 40, didn't hit anything. So how I use that as a structural exemplar is, the non-Indigenous people that were walking by it as if it was, "Oh, a park," or "Isn't that interesting?" If they saw it at all, it didn't mean anything to them, they're walking their dog by it. Their kids are running up and down the ramp where you would go and get hung, and playing on it, it didn't mean anything to them.

It's a structure big as life, didn't mean anything. The Indigenous people along the sidewalk were putting up, take it down, and our genocide isn't your art, just tons and tons of posters crying, it's re-traumatizing them. And to me, that's it. Non-Indigenous people don't have to see these structures that are as big and solid as that. And if they do see it it's like, "Oh, well" whereas indigenous people are re-traumatized day after day after day. The \$20 bill with Andrew Jackson on, I mean, it's like every day you can name something everywhere, and nobody's noticing. So the last thing I'll say is, when you hear the people with all Black and Brown populations to you saying, "Why don't you get over it?" and "it was 200 years ago. It was 300, whatever." One of my favorite sayings stop mine is, invasion isn't an event, it's a structure. So it's not just in 1492 this happened, so get over it. This gallows is just right there in our faces every day and until that's gone with just as many laws and acts here we are, and then people wonder why can't we get over it.

**Dr. Maybank:** Absolutely. Dr. Nunez, I don't know if you have—

**Dr. Nunez-Smith:** Yes.

**Dr. Maybank:** Something you can—

**Dr. Nunez-Smith:** Yeah. Thank you. And my heart is racing now just here in this. My whole body is reacting, it's just a visceral reaction. And the comment I wanna make is potentially, relatively

mundane, but one of the things that I struggle with a lot and I think about a lot is sort of our data, and some of the structural, right? When we think about the structures and just where our data systems continue to commit violence on people in the invisibility. So even as we talk about Indigenous lives, right? How long did it take us to get the data on what was happening in tribal communities and Indigenous people in COVID-19? Do we even think we have a complete data picture right now? No, we do not.

And so, this question about kind of structural remedy, it's the question and it's where we need to be, and it will carry with me that what we're talking about today were not events, this is legacy, structural legacy. But one of the things that I think is really important is for us to, not data for counting, but importantly not data for counting sake, but data for accountability sake, and data for us to respond and intervene for that purpose and that sake. And so, in this long list of things that we need to do, one of the things is, we have to make the invisible, visible more in our data systems with ways to really hold ourselves accountable.

**Dr. Maybank:** Thank you. And we have, literally, two minutes. I think these conversations always go this way which is a good thing, we want to talk more. But as we kind of close out, you just mentioned data for accountability which I think is absolutely critical. Do you just want to say kind of one thing that you—so we know the structural and need for structural approaches and solutions, what are some other kind of short term immediate opportunities for action as it relates to trust or messaging? And so, we'll just do a really quick round robin and so that we can try to finish on time on this. Dr. Corbie-Smith.

**Dr. Corbie-Smith:** I'm going to pass and come back to me because I don't have two minutes, I have like five minutes.

**Dr. Maybank:** I hear that. So, we'll go to Dr. Smith and then you'll try to figure out how to get it into—

**Dr. Smith:** I like the way she punted and made me have to go ... I guess to two things quickly, one is around figuring out a way to address, confront misinformation, false information, misunderstandings, disinformation to figure out what are the right channels and ways to do that. And the second is around, actively eliminating, that is reducing, the functional barriers to testing and to vaccination because there are so many of those; where it is, time of day, does it cost, what if people are scared if they have a side effect they won't necessarily be able to have time to sort of see about that. All those functional barriers need to sort of be addressed.

**Dr. Maybank:** Thank you.

**Dr. Corbie-Smith:** I could jump in now if you're okay.

**Dr. Maybank:** Go ahead.

**Dr. Corbie-Smith:** So for me, it's about our health system and our scientific community realizing that it has a racism problem and addressing and demonstrating the trustworthiness of those institutions through, as Lauren has said, transparency, honesty, as well as giving patients, providers and health systems, really the patients and providers honoring their authority, autonomy and making it easy for them to make a decision that's in line with health. And working with communities, our health care professional communities to build that trust, and having those individuals as part of the decision-making and the messaging going forward.

**Dr. Maybank:** Thank you. Dr. Moss.

**Dr. Moss:** Again, I would say assume trauma as you're approaching the individual patients, therefore you have to have in your back pocket and if you don't, we need to get provider-patient concordance to be able to provide culturally relevant communication and understanding, or they're not going to trust. So it should have started long ago, but if we can find people that can be trusted now and often that's the elders, so there already have to be a communication with them first and then hopefully it would snowball.

**Dr. Maybank:** Thank you for that. Dr. Gallon.

**Dr. Gallon:** I can give a really quick, but concrete example. So the COVID Collaborative, which I think comes out of Harvard and a bunch of other institutions with the Ad Council, just announced that there's going to be \$50 million unprecedented amount of money to vaccine education and in campaign. I would love to see some of that money, a lot of that money go to Indigenous media organizations, Black media organizations, grassroots organizations that are on the ground in the fight every day working with Black community. So we can get some more resources into the hands of the people that are on the front lines literally, I think we could start really seeing some change happen.

**Dr. Maybank:** I agree, and the collaborative actually has a lot of great leaders within that collaborative that are building so definitely check that out. And Dr. Nunez-Smith, anything else that you wanted to say at this point?

**Dr. Nunez-Smith:** Yeah, I go and lift up all. I mean, I think it's so important the partnerships are going to be key. That's critical from the beginning—co-design, co-ownership of all these messages of all the initiatives. And like I said earlier, I think there's an important role for the federal government and the new administration to play in terms of unifying some of this information as it comes out. So thank you for having us all here today, really great discussion and we have lots of work to do.

**Dr. Maybank:** Absolutely. So thanks to all of you, all the guests today. For those who want more and

more conversations this will be posted a little bit later today so you'll be able to share it, but also keep your eyes out. We are going to have eyes and ears out a special edition with Dr. Camara Jones and Dr. Uche Blackstock, also talking about vaccines and trust, and we'll have that available. Just a reminder that you can check out our AMA website and our equity resource center that we are working to continually evolve. And I just want to say thanks to all the people who are really putting their lives on the line every single day from health care worker, to the store salespersons, to transportation workers, thank you for all the work you're doing. And then lastly, on behalf of the AMA Center for Health Equity, we really wish everyone a safe and healthy holiday. Please wear your mask, wash your hands, watch your distance and we will see you back in the new year. Thanks a lot.

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