SIDEBAR

# How Our Sister-Circle of Six Black Female Physicians Fought Health Care Inequities to Deliver a Dose of Hope

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By the time we started our COVID-19 vaccination clinics in Wake County, North Carolina, on January 24, 2021, over 375,000 Americans had already died of COVID-19 and national death rates were at over 3000 daily [1]. It had been nearly a year since COVID-19 rocked our country to its core, and the confluence of both racial and viral pandemics amidst a related political storm felt nearly overwhelming.

By that time, our group of six Black female doctors had already come together to provide support to each other in ways that Black women often do. With only 2% of doctors in this country being Black women, we had already experienced years of professional and personal challenges that we rarely talked about outside the confines of our safe spaces. The added focus on centuries of racial tensions was an additional psychological strain as the impact of racism took center stage. As frontline doctors representing the fields of pediatrics, psychiatry, family medicine, obesity medicine, and obstetrics and gynecology, we witnessed the devastating impact on families, including our own; COVID-19 was killing people who looked like us at nearly three times the rate of the general population [2].

When the dream of a vaccine became a reality, we were particularly concerned that vaccine hesitancy in the Black population would be another strike against us in combating the death rate. Though many Americans had important reservations about the COVID-19 vaccine, in the Black community, concerns about its safety and the use of newer technology were magnified by the additional fears that we would be physically harmed at one extreme and, at the other extreme, benefit less because of unequal access.

We intimately knew that the concerns of Black people are deeply rooted in the legacy of racism that has caused us both physical and psychological harm. From recollections of how treatment was purposefully withheld from sick Black people during the Tuskegee Experiment [3] to confronting trauma from a history of forced sterilization through eugenics programs [4], part of the landscape of governmental mistrust is the historic lack of oversight by medical professionals who ignored their ethical obligations to prevent these atrocities.

Early polling that explored vaccine hesitancy in Black communities toward the end of 2020 additionally revealed that 79% of Black adults believed racial discrimination in health care was an obstacle to care and 71% reported that racial bias had personally affected them [5]. As physicians of color who are not identified on sight as being medical experts, many of my colleagues had personally experienced racial biases that often resulted in inferior access to health care.

In our home state of North Carolina, the disparity in early vaccine access was alarming, with early data showing over 82% of those vaccinated were White compared to only 11% of Blacks. When categorized by ethnicity, only 2% of vaccinations were given to those identifying as Hispanic [6]. This is despite a population in North Carolina that is 23% Black and 10% Hispanic/Latino; these disparities were mirrored in early data from other cities and states around the country [7].

So when my colleague, Dr. Rasheeda Monroe, volunteered for the first drive-through clinic at our health care institution and saw a vast majority of White faces, she immediately knew that she had to call upon our hospital system to prioritize vaccinating historically marginalized populations. They didn't know how to do it, but she knew we did.

Our game plan was to directly contact the people and institutions that interface with Black people every day. In these early phases of limited vaccine availability, that meant our Black churches and community organizations. We knew that a reliance on technology limited outreach to those who are more economically privileged, younger, and White. We counted on direct communication, knowing that advertising our efforts publicly would invite an onslaught of people from outside our targeted communities [8].

Secondly, we understand that there are certain areas in our county that are disproportionately impacted by poverty and disease as a result of intentional government-sponsored segregation. Located in the Southeast region of Raleigh, it was not a coincidence that the 27610 ZIP code was the worst affected by COVID-19 deaths in Wake County. Though we were able to hold our first vaccination clinic as part of an already-planned drive-through by recruiting over 700 participants within a 48-hour period,

we knew that we needed to physically bring the vaccine into spaces that our community members, including the elderly, already frequented prior to the pandemic: namely Black churches, community centers, and neighborhood schools.

Finally, we inherently knew that the messaging regarding the safety of the vaccine and the importance of getting it had to come from people who looked like us. We understood the mistrust and pain our community experiences within our field of health care. We knew we had to actively participate in not only vaccinating but also providing education so we could address the concerns of our community. We counted on the incredible volunteerism of health care workers and community members who felt helpless in stemming the isolation and death caused by this disease and needed to do something tangible to heal their own psychological wounds. We were intentional about our teams being led by mostly Black physicians, understanding our position as trusted messengers. While our group was not solely responsible for the rise in Black vaccination rates during this time, Wake County officials told us we had a significant impact. North Carolina Department of Health and Human Services (NCDHHS) vaccination data for Wake County reflected that after every weekly vaccination event we held, the vaccination of Black communities rose by almost a full percentage point (NCDHHS, email communication). After vaccinating 7000 people, we were able to hold our last large clinic on April 24, 2021, to coincide with the extension of vaccine availability to everyone in Wake County who wanted one. As of May 26, 2021, vaccination levels among North Carolina Blacks had risen to 17.8% of the vaccinated population and the level among Latinos had risen to 6.9% [9]. It is clear that there is still much work to do. We continue our work even now in response to the rise of more contagious variants, in hopes of helping our communities navigate through land mines of misinformation and fear.

As a nation, we should acknowledge that people of color often have a different experience within our health care system. While we know that there are no biological differences between White and Black people that can account for health disparities, poorer outcomes demand that we confront the massive impact that racism has on public health. The complexities our viral and racial pandemics have caused present an opportunity for us to improve our systems of health care delivery. While we are witnessing the results of scientific innovations that have been in development for years, we are handicapped by having ignored the source of the distrust in our institutions held by many. We owe it to our most vulnerable populations to finally get this right. NCMJ

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## References

1. Coronavirus in the U.S.: Latest Map and Case Count. New York Times. Updated July 13, 2021. Accessed July 13, 2021. https://www.nytimes.com/interactive/2021/us/covid-cases.html
2. Center for Disease Control and Prevention. Disparities in Deaths from COVID-19. Updated December 10, 2020. Accessed July 13, 2021. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/disparities-deaths.html
3. Nix E. Tuskegee Experiment: The Infamous Syphilis Study History.com. Updated December 15, 2020. Accessed July 13, 2021. https://www.history.com/news/the-infamous-40-year-tuskegee-study
4. Ko L. Unwanted Sterilization and Eugenics Programs in the United States. PBS.org. Published January 29, 2016. Accessed July 13, 2021. https://www.pbs.org/independentlens/blog/unwanted-sterilization-and-eugenics-programs-in-the-united-states/
5. Hamel L, Kirzinger A, Muñana C, Brodie M. KFF COVID-19 Vaccine Monitor: December 2020. Published December 15, 2020. Accessed July 13, 2021. https://www.kff.org/coronavirus-covid-19/report/kff-covid-19-vaccine-monitor-december-2020/
6. North Carolina Department of Health and Human Services. Vaccinations. Accessed July 13, 2021. https://covid19.ncdhhs.gov/dashboard/vaccinations
7. Johnson CK, Kastanis A, Stafford K. AP Analysis: Racial disparity seen in US vaccination drive. AP News. Published January 30, 2021. Accessed July 13, 2021. https://apnews.com/article/race-and-ethnicity-health-coronavirus-pandemic-hispanics-d0746b028cf56231dbcdeda0fba24314
8. Goodnough A, Hoffman J. The Wealthy Are Getting More Vaccinations, Even in Poorer Neighborhoods. The New York Times. Published February 2, 2021. Accessed July 13, 2021. https://www.nytimes.com/2021/02/02/health/white-people-covid-vaccines-minorities.html
9. North Carolina Department of Health and Human Services. Promoting COVID-19 Vaccine Equity in North Carolina. NCDHHS; 2021. Published May 26, 2021. Accessed August 6, 2021. https://covid19.ncdhhs.gov/media/2388/open

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