Episode 4 – Vaccines & Medical Mistrust

With Dr. Shantel Hebert-Magee

Diane (00:00):

We hear about vaccines every day, but do you know the facts? Welcome to Vax Matters where we explore the truth behind vaccines. I'm Diane Deaton.

Deon (00:11):

And I'm Deon Guillory.

Diane (00:19):

Hi, Diane Deaton here and welcome to Vax Matters where we explore all matters related to vaccines. If you're joining us for the first time, we are covering everything from the first vaccine ever developed to all the new vaccines being created today. Joining me, Deon Guillory.

Deon (00:39):

Hi, Diane. It's great to be with you as always, you know, it's hard to believe that we've already covered so much information about vaccines but yet here we are.

Diane (00:47):

Indeed amazing, isn't it? We've talked about COVID then covered the long history of vaccines and today we're going to discuss a sensitive topic but one that needs to be talked about and we're the people to do it.

Deon (01:01):

You're right about that Diane. In today's episode, we're gonna take a closer look at minority mistrust of vaccines, specifically, and the U.S. healthcare system in general. And joining us for that discussion is Dr. Shantel Hebert-Magee. Dr. Hebert-Magee joins us from New Orleans as one of our regional medical directors with The Louisiana Office of Public Health. Welcome Dr. Hebert-Magee. Thank you for being our guest.

Dr. Hebert-Magee (01:26):

Thank you for having me.

Deon (01:27):

Let's get started with it because there's a lot to go through here. Um, what exactly is medical mistrust?

Dr. Hebert-Magee (01:34):

I would say medical mistrust can be defined as a skepticism or weariness of medical personnel, uh, medical institutions as well as ad- advancements, uh, including vaccines. Medical mistrust is oftentimes rooted or predicated, um, in cultural mistrust, meaning that there are subsets of the population that don't identify with the mainstream majority society and have a distrust and that can be various people who feel that there are on the fringes. Also, medical mistrust is not just a doubt of the medical system, but it's the belief that this entity or the products that they are trying to, um,

administer may actually cause harm and be against one's, you know, best interest. So, it's a pretty complicated, um, issue.

Diane (02:33):

And, and to lay the groundwork doctor, we're talking about, unfortunately, certain, like you said, segments of the population or certain communities, is that right?

Dr. Hebert-Magee (02:45):

Yes. So, um, typically it is our minority population. So, whether we're talking about African American, Latinx, Native American, low wage earners, um, individuals who, um, have previously been incarcerated, um, individuals who are undereducated, the homeless population, those who feel that they have been marginalized who feel more vulnerable and they just don't identify with mainstream middle class, white America. And, you know, because they feel that they are not part of the larger populace, um, sometimes they don't think that their humanity is valued.

Diane (03:26):

And this didn't just happen overnight. This has been a long time in the history of these, uh, these folks and these, these communities.

Dr. Hebert-Magee (03:35):

Yes. Um, indeed. I think, um, unfortunately the narrative, um, in this country, particularly in the south, we know the past, um, has been marred by very painful experiences. In different populations, um, have legacies that have been tarnished because of these painful experiences. So, whether we're talking about, um, the Tuskegee experiment, whether we are talking about, um, experimentation upon enslaved individuals. But, you know, to speak to, you know, I guess some of our earliest, um, exposure, um, even when the American colonists, right? The new Englanders were, um, first settling in this country, um, they had an epidemic of smallpox and, you know, they were so concerned about the spread and one of the things that happened is that Cotton Mather who happened to be a Puritan minister, uh, leader, Harvard graduate, um, and he was also very keenly interested in medicine, had spoken to one of his slaves and asked him did he know anything about small pox? And he says, "Yes."

Dr. Hebert-Magee (04:42):

"In my homeland, we would take and, take scrapings from, you know, one of the scabs of someone who was infected, it we'll scrape our skin and get a very mild, um, version of this disease." And so, Cotton Mather tried to bring that to the colonist. However, they were so skeptical, they were afraid that the indigenous Native American population, as well as the African population wanted to eradicate them, that they wanted to remove them from society. So, they were very pensive about doing it and some of the colonists did do it and they actually survived. And so, this brings me to the point, I guess, the irony is that today we have minority populations who also feel that vaccines were intended to eradicate those that are unwanted, those that are considered, you know, less than desirable and that has been one of the, uh, most difficult aspects of trying to, um, provide vaccines to the community.

Deon (05:46):

And you mentioned some of the, uh, the cases you mentioned, uh, were that there, some of the reasons why African Americans have medical mistrust, but also, um, Native Americans have a h- a historical medical mistrust in the U.S. government. Can you tell us about that story?

Dr. Hebert-Magee (06:03):

Sure. So there are several incidences, um, but one of the earliest also happened, um, while we had the, um, American colonies. Um, one of the things that, um, the British loyalists did is that they actually took and gave, um, blankets that had been, um, previously used by soldiers who had smallpox. They gave them to these Native American, um, tribes causing biological warfare. I mean, literally they gave them something that was contaminant and that they knew their immune system, um, had never been exposed to, intended to eradicate that population. And even, you know, as recent as the 1970s, um, there were, um, targeted s- sterilization programs that were implemented, um, to try to prevent, you know, Native American women from procreating so they wouldn't be able to have children. I mean, who, with, who do we think has the authority to tell someone that they are less than desirable?

Dr. Hebert-Magee (07:10):

But, I mean, it's not only African American and Native American populations. This was done to those who were considered, uh, feeble minded, those that were considered, um, disabled, um, less than desirable, undereducated, rural populations. Um, Fannie Lou Hammer was a civil rights advocate and she talked about as a child, a young girl, she thought she was having an appendectomy and it was called a Mississippi appendectomy because they actually removed her uterus.

Diane (07:40):

Oh gosh.

Dr. Hebert-Magee (07:41):

She had a hysterectomy unbeknownst to her.

Diane (07:43):

Oh gosh.

Dr. Hebert-Magee (07:43):

Yeah. And it wasn't until she got married and started trying to have kids and, you know, she went to doctors and ultimately, they realized that she did not have a uterus and her husband left her. And so being bereft of the opportunity to actually have children and it's not natural, um, it's not anything that you've done but someone else made a decision without your knowledge. I mean, these are atrocities that people don't forget, and they imbrue our memory.

Dr. Hebert-Magee (08:15):

And the reality is that our medical community has been in denialism for a long time, you know, these are uncomfortable subjects. You know, my grandmother, she, um, you know, she would always say, "Let the past remain in St. Louis Number 2" And for those who don't know St. Louis Number 2 is one of the enrolling cemeteries. So, leave the past in the cemetery because sometimes it's too painful, it's retraumatizing and this re-traumatization, people can't handle it and there are triggers. And so, I would say for these populations, even though we talk about things that happened in the 1970s and

in the 1770s, the vestiges are still here and there are triggers and sometimes it's just hard to move forward and not consider the pain that it's caused.

Diane (09:07):

I find it remarkable. As you said, when you were talking just a moment ago that this, some of these things happened as recently as 1970, that, most of us that's our lifetime. This isn't something that was back in the history books and it's just remarkable when you start doing all the, um, the research and you find out what's happened. You, you mentioned Tuskegee. What, what was that about doctor?

Dr. Hebert-Magee (09:33):

So, the Tuskegee, um, experiment actually, um, it was meant to be a study, um, funded by, uh, Julius Rose- Rosenwald. So many of us are familiar with the Rosenwald Fund. There are, uh, various gymnasiums around the country that have been named after him. He was a philanthropist and he worked very closely with, uh, Booker T Washington. And he believed in community healthcare, so he wanted to, um, be engaged in Tuskegee where they had this pre-eminent black institution that was doing a lot of work around agronomy and botany and working with agriculture and, and additionally, he also wanted to address some of the ailments, realizing that these rural populations didn't have the same access to healthcare. So, this is someone long time ago, realizing that our healthcare delivery model was not equitable. But what happened is that all the funding that was supposed to go towards providing medication for individuals who were going to participate in the Tuskegee study was lost because The Great Depression happened and pretty much all the money was gone.

Diane (10:41):

Wiped out, yeah.

Dr. Hebert-Magee (10:41):

So, what happens that the scientist, right? All the health investigators, the nurses, the doctors, everyone involved say, hey, we can continue with the study, and we can just observe the natural course of the disease. And the issue is that penicillin became available, which we knew could cure people of syphilis and stop the progression of the disease and prevent people from dying, prevent people from becoming, you know, where they were no longer able to ambulate or walk, prevent neurosyphilis where they would become, you know, a type of dementia that would develop. That was able to be prevented with the simple use of penicillin. However, they did not have respect for the humanity of these men that were enrolled, the impact they could have on their families, on their children, on their spouses, because in the name of science, these individuals were considered specimens, they were considered guinea pigs.

Dr. Hebert-Magee (11:45):

And that's why people wonder even now when they go to the doctor's office, do they see me as a person or do they see me as simply being, you know, a condition? They see me as being a, you know, a research trial participant. Do they see me as someone that they would respect? Someone that they would cherish? Someone that they identify with as themself? And the reality is that many people of different persuasions are concerned when they go to various medical facilities that they will not be seen for who they are and will only be seen as that condition or as that medical record number.

Deon (12:26):

Mm-hmm. Another one of the cases of that, uh, a lot of people may not know about, um, and you can really, uh, give us some insight on it is, uh, the one about, uh, Henrietta Lacks.

Dr. Hebert-Magee (12:38):

Yeah. So once again, Henrietta Lacks, um, happened to fit many of the demographics that we're talking about, um, you know, poor, um, rural, uh, black woman. And unfortunately, we know that there are still issues when it comes to black women's health, uh, to this day. And, um, you know, she had been diagnosed with cancer and unwittingly, um, tissue samples had been removed from her and used, you know, for numerous years, all over the world to advance medical science. And it's wonderful for someone to say that they were able to contribute to, um, advancements in, you know, in cancer therapeutics and all different types of, uh, treatment options. Nonetheless, she never gave permission, they never asked her if they can take samples from her body to use for this purpose. Um, I mean, I would not-

Diane (13:37):

And her family didn't know about it either, did they? Her family never was aware of this?

Dr. Hebert-Magee (13:41):

No, no. They had no idea. And so, and, and that's the, you know, the weariness, right? The suspicion, the concerns that people have is, it's not only that you will harm them but that is a lack of respect, it's a lack of autonomy. People wanna think that they have control if, if not over what happens to them in life at least I have control over my own body, that I haven't been violated. And so, I mean, it's not just a violated, violation of trust. It's literally that you have permeated my body and have acquired materials without my permission and have disseminated my cells because they became an immortal cell line, meaning that they were able to, typically when they do cell cultures they live for a certain period of time and then the cells die. So, it's hard to have continuity when you're doing research if the cell line keeps dying. But miraculously, you know, she had this cell line, if they were able, you know, given the right nutrients and the right environment to continue to, you know, replicate and unfortunately, you know, they never received any proceeds, they never received, um, any acknowledgements and, I mean, it's just unfortunate that there's a complete disregard for her and her family.

Dr. Hebert-Magee (15:05):

And, um, but this is not the first time and I think people are afraid that it would not be the last time and that's why there continues to be so much, um, hesitancy when it comes to, um, you know, participating in medical trials. I've had, you know, patients, um, for years I worked with industry, um, with device development in order to improve, um, outcomes for, um, patients. And typically, I worked with early detection devices, meaning that we're trying to te- detect cancer in individuals early enough that we can prevent them from having a negative outcome. And, um, we had clinical research nurses. They would go and consent patients and ask them do they wanna be in their trial?

Dr. Hebert-Magee (15:49):

And, um, occasionally they would have a minority patient and they really wanted to get them in the trial so we can have more diversity and unfortunately, they were reluctant. And so, they would ask for me to come into the room and I would go in and I would introduce myself and then they would ask me, "If I entered this trial, am I gonna get the good stuff?"

Deon (16:11):
Mm-hmm.

Dr. Hebert-Magee (16:11):
Now stuff is not the word that they always used-

Deon (16:14):
Right.

Dr. Hebert-Magee (16:14):
... but they said they wanted to know were they gonna get the, the product, the medication, the tool, uh, that was going to improve their quality of life and possibly prevent their disease, um, from worsening? And I couldn't promise them that because in research we do randomized, double-blinded control trials, where neither the researcher nor the participant know which arm of the trial they're in. But why would you wanna parcit- why would you wanna participate in a trial if your experience in life has always been, you have been considered inadequate, you have been oppressed, you have never had opportunities?

Dr. Hebert-Magee (17:01):
So, if you are finally offered the opportunity, please put me in the arm of the trial that's going to give me the cutting-edge technology or that's gonna give me, you know, this medication that may possibly add something more than what you currently give everyone else. No one wants to be relegated to the placebo. And I think for many minorities, they feel that either they are the placebo, or they've been given the placebo, meaning that they're just part of the status quo, they're not considered a high valued individual. And it's hard to have those conversations because as we've been discussing thus far, um, there are many layers to this and we can't just, you know, forget about the past, we can't negate the past and we can't ignore the fact that the injustices are still ongoing.

Diane (17:57):
And it doesn't happen overnight as far as trying to correct a wrong or to do something about a wrong and to have people with a different mindset, it takes time. And as you said, this is going on today in this day and age when you want people to be involved in, in a trial, it's like, oh gosh, I don't know. It's almost to the point that they would say, "Well, if it were your choice, doctor, would you, do it?" And that's why it's so important to talk to a doctor, talk to somebody that you trust.

Dr. Hebert-Magee (18:31):
I, I, I completely agree. Um, the reality is that many people don't have a relationship with a primary care, uh, provider. Um, you know, with the passage of Medicaid expansion in 2015 in the state of Louisiana, um, hundreds of thousands of people have, um, enrolled to receive, um, healthcare insurance. That was something that didn't exist for, um, huge segments of our population yet their habits haven't changed even though they now have access to healthcare insurance. They still go to the emergency room, they still go to urgent care centers because that's the relationship that's always existed.

Dr. Hebert-Magee (19:14):
Um, and so until you actually forge a relationship with the provider, someone that you trust, um, it's hard to get people to be receptive to something that's new, you know, it can be undaunting if

someone surprises you. So, we like what we know, you know, we like to have continuity, we like to have, um, you know, a routine, you know, I mean, sometimes, you know, I drive to work in the morning and I wanna go a set way and then there's a roadblock, right? And you're like, oh, you're frazzled.

Diane (19:46):

(laughs).

Deon (19:46):

Yeah. What do I do now?

Dr. Hebert-Magee (19:46):

I mean, it may only take me two minutes longer, right? (laughs).

Deon (19:51):

Yeah.

Dr. Hebert-Magee (19:51):

But you're completely frazzled because your routine has been disrupted. And so for people who for years, for generations, the only time they go to the doctor is when they have a serious ailment, it's hard to disrupt that routine and tell 'em to come in for preventive checkups, to tell 'em to come in and get their colonoscopy, their mammogram, you know, to come and get their pap smear because, you know, that may not be something that is considered to be a priority for them at this time because they have more extenuating circumstances.

Dr. Hebert-Magee (20:25):

Um, you know, as a kid, I would go with my grandmother to the grocery store, I called her Mama Mere and, um, and I would ask her while we were, you know, walking down the aisles, I would point to different items and I would say, "What's that?" And she would say, "That's not for us." And I'll say, "Okay," walking down the aisle, "Well, what about that?" And she would be like, "No, we don't, we don't, we don't eat that." So, I learned as a child that there are things that are insular to my community and things that are foreign to my community and things, she was pointing out were sauerkraut, like, you know, we don't eat sauerkraut.

Deon (21:00):

Oh.

Dr. Hebert-Magee (21:01):

So (laughs), so we didn't eat pickled cabbage but yet we ate pickled meat.

Deon (21:05):

Right.

Dr. Hebert-Magee (21:05):

I mean, that's a staple and red beans and rice in Louisiana, you know, we didn't eat, eat yogurt but we ate Creole cream cheese. So, the, the point is that there are many communities that are insular

and they're insular in order to protect themselves. And so, the same way they may not believe the sauerkraut isn't for them, they may not believe certain music isn't for them and they may not believe a certain medical advancements aren't for them such as the COVID vaccine, that wasn't intended for us. So you have to see people where they are, we can't be reductive, we can't negate their experience and so we have to have these open dialogues and conversations, um, in order to really try to address the issues head-on.

Deon (21:53):

Yeah, we, such a great explanation as to how different people, uh, see things and think things especially for the generations, like, it can be passed on. And, you know, through our conversations so far, we've talked about African Americans and Native Americans and their distrust with the medical community. Also, those who are Latinx have that same distrust and, you know, a q- about a quarter of those who are Latinx are undocumented, and they are afraid to get medical care for fear of being reported. Doctor, would you say that this is the biggest obstacle for them in, the, with their trust in the U.S. health system or are there other factors that are here in play too?

Dr. Hebert-Magee (22:41):

I would say that is one of the major obstacles. Um, I think families are afraid that this is a ploy by the government to get them to come out to a community vaccination event, get their information, realize that they are undocumented and then deport them. I actually had, um, an individual tell me that they were so concerned about coming to the event because the fear of being separated from their family in life was worse than the fear of being separated from their family in death.

Diane (23:15):

Oh my goodness.

Dr. Hebert-Magee (23:17):

Yes, meaning that they would have rather died from COVID knowing that, you know, maybe this couldn't have been prevented if a vaccine didn't exist, but they wouldn't want to willingly have gone to an entity or an event and gotten a vaccine, expose their family and then be sent to a country that may have warfare or may not have, you know, provisions in order for them to survive and never be able to see their family again. They said they couldn't live with themself and so they wanted the reassurance that this was not some, you know, devious plan that has been concocted to try to get ICE to show up at a particular location. And for that very reason we had to have the events at sanctuaries, literally sanctuaries, where people think that they can get asylum, you know, a safe haven, a refugium where they know that, hey, the church is not gonna let them come in and take me.

Deon (24:22):

Yeah.

Dr. Hebert-Magee (24:22):

And it's sad that that's where we had to have the majority of our events. You know, we also had them at some of the local grocery stores that they, you know, frequent because they have, you know, particular delicacies or fruits and vegetables that are native to their countries, um, at these locations but it was important that we have that safe haven. Um, but additionally to concerns about being arrested, detained and deported, they were also, um, concerned about the cost. So, we've always said that the vaccines are free yet when they show up to the event, typically the provider

asks for insurance and many don't understand that, right? They say, "Why do you need my insurance if this is free?" Well, the insurer gets charged but the actual, you know, person should not receive a charge, but they were concerned.

Dr. Hebert-Magee (25:14):

I mean, many of them are day laborers, you know, they're undocumented, they're wage workers and someone telling 'em they, they have to pay $20 or $30 for a vaccine can be a deterrent because that can go towards gas or an electricity bill or putting food in the mouths of their kids. So, they would walk up and then, you know, they would say, "Gratis, like, is this free?" And we would say, "Yes." And then when we would ask for the insurance card, they would turn and walk away. So, I had to speak with those providers and say, "Please do not ask for insurance unless it's, you know, absolutely necessary because this particular population that may lead them to turn away and not get vaccinated on this date."

Diane (26:01):

As you-

Dr. Hebert-Magee (26:01):

And so, hmm?

Diane (26:02):

And as you said, I'm so sorry to interrupt. And as you said, there is that, that barrier, that comfort, we must respect their comfort level and there is the language barrier, you know, it's just, they, they don't understand.

Dr. Hebert-Magee (26:16):

Absolutely. And, um, that was one of, you know, our biggest issues initially when we were trying to, um, roll out our vaccine delivery model is that we had to have people that spoke their language, right? And it's not just being proficient in the language, it's, you know, sharing that voice, you know, people want to hear and see people that they identify with, right? You look for the familiar face in the crowd, you know, it's like having your school recital and you're looking for your parents, you're looking for that comfort. And for many of them, it's the clergy members, it's members that, you know, um, have helped them in various ways.

Dr. Hebert-Magee (26:56):

So, whether they go to food banks, whether they've gone to, you know, or participated in clothing drives and seeing that person that you recognize, um, you know, it provides some sense of comfort, some solace that this is a safe space for me. And, uh, we make every concerted effort to try to do that as much as possible, um, in order for them not only to come out, but what would happen is that someone come out pensively, they will observe, you know, then they may get vaccinated and then two hours later they bring a family member or a relative or, you know, the neighbor next door. So, you know, once we gave them that reassurance that this is a safe space, we were able to actually, you know, reach some of those in the population that were on the fence.

Deon (27:47):

And that shows a perfect example of why representation matters.

Dr. Hebert-Magee (27:47):

Absolutely. So, and I think that's one of the gaps or chasms that we have to address. Unfortunately, when it comes to, um, you know, Native American physicians, I mean, it's less than a percent, when it comes to African American phys- physicians, um, it's between two or 3% of all doctors. So, you know, people want to see someone who's in the room that they identify with. Um, you know, Langston Hughes talked about American heartbreak, and he talked about the double consciousness of being, you know, both American and Negro. So, we're talking about being American and Black, American and Latinx, American and foreign born, American and disabled, American and old, um, or being a, um, a gender or racial, uh, a, sorry, a gender or religious minority, um, there are people who just don't feel safe because they feel that people don't recognize them and accept them for who they are.

Diane (28:55):

What do we do, doctor? It's, kind of, a conundrum. What, what do we do?

Dr. Hebert-Magee (29:01):

I mean, I think the first thing we need to do is acknowledge the past, um, be transparent, you know, don't try to whitewash, you know, history and say that these things didn't occur or that it's a different time. Also acknowledge that, um, you know, the issues are still ongoing, that there's a lot of social and political, um, factors that impact, um, a patient's or a client's, um, healthcare and wellness and there are substandard living conditions, there is subpar educational systems that certain communities are relegated to, certain communities are, you know, over, um, you know, they have a lot of, um, over policing of those neighborhoods. I mean, the simple fact is that there are neighborhoods within our community that have interstates that are directly above their homes. So, every time-

Diane (29:56):

Right. And run right through them.

Dr. Hebert-Magee (29:58):

(laughs). Exactly. And so not only are we talking about pollution and debris, I mean, what are, you know, how does that affect your ability to feel, you know, safe walking around your neighborhood, um, because there's poor lighting so you have a sedentary lifestyle? There are neighborhoods that are inundated. I mean, any of us can recognize certain neighborhoods and, sort of, guess who we think are, you know, the residents in that neighborhood, if there is a Panera Bread, a Trader Joe's, we say, oh, this is probably a nice swanky part of town. And yet if we see a bunch of fast-food restaurants, you know, all together that have, you know, I mean, food that is highly, you know, unhealthy, we know those targeted populations as well. And it's unfortunate because it affects asthma, you know, it affects, you know, people who have, um, COPD, you know, those who have diabetes.

Dr. Hebert-Magee (30:54):

And so, we have to change, we have to review, we have to, um, revise and enact policies and laws that address health equity, we have to, um, engage community stakeholders, um, that people trust. And then we have to, you know, address the need of a person, not only based upon their condition, but seeing them as an individual. So, when someone goes to a doctor's office, right? It could be a podiatrist and they can ask them, "Have you gotten your, you know, flu vaccine?" Um, you know, they can go and see, you know, their eye doctor because that may be the only physician that they

see. They may never go and see an endocrinologist for their diabetes, but they're going to check on their feet because they gotta get to work and they don't wanna lose a limb.

Dr. Hebert-Magee (31:51):

So we have to realize and catch people where they are, meet them where they are and look at them in total and not just look at them, you know, for diabetic neuropathy and ask, can their, you know, can they feel their toes? You know, ask them what they feel in their heart, discuss their issues. Um, and so we need to have a diversity of providers, we need to have providers that are not only culturally competent, but they have humility and they're able to, you know, recognize that maybe they haven't walked in someone's shoes so don't, you know, underestimate their lived experience. Then we have to have stakeholders that are going to ensure that we have all the wraparound services, um, until we're able to get provisions into some of those neighborhoods that desperately need it through laws and policies.

Diane (32:41):

And, uh-

Deon (32:42):

And, and I think you're so correct when you were saying too, and you just, kind of, hit the nail on the head, talking about to have the empathy-

Diane (32:49):

Hmm.

Deon (32:49):

... to have the emotion, you do not exclude anys- anyone's experience and no one is expendable, no one.

Dr. Hebert-Magee (32:59):

I, I absolutely agree. I, um, you know, in, in my training, um, you know, I would come across, um, patients who still, as I say, they talk that Nola Yat, or that, you know, South Louisiana bayou talk.

Deon (33:14):

(laughs).

Diane (33:14):

(laughs).

Dr. Hebert-Magee (33:14):

So, you know, and they'd be like, [foreign language 00:33:16]. You know, I be like, [foreign language 00:33:19]. And so then, you know, they'll go into talking and so I have this one patient and, you know, I asked, I said, "Why are you here?" And they said, "I can't get the water come out the pipes." And, and so the, the, uh-

Diane (33:36):

Okay. It takes a minute. Yeah. Okay (laughs).

Dr. Hebert-Magee (33:39):

(laughs). And so, so the, you know, my, uh, you know, co-resident said, "Um, are you a plumber?"

Deon (33:46):

(laughs).

Dr. Hebert-Magee (33:48):

And it, and it didn't [inaudible 00:33:48] (laughs). But they were saying that they had some urinary issues and-

Deon (33:52):

Uh-huh.

Dr. Hebert-Magee (33:54):

... and, you know, older gentlemen, some prostate issues. And so, so there was some urinary hesitancy that he was experiencing, but, you know, he didn't have the vernacular or the lexicon to be able to, you know, exactly say what was going on with him in medical terminology but he said it, you know, how he could best explain it. And, um, and so you have to be able to, um, you know, hear a person, identify what their experience and, um, you know, just recognize 'em for who they are. I mean, the reality is that we do have people who come in who are disheveled, people who come in who, um, have behavioral health, um, conditions, individuals that may come in and they have a certain aroma that may, you know, not be the scent that we wanna smell, but we don't know what has led that person to be in that condition and so we are supposed to be that safe haven and we're supposed to be, you know, that community that actually looks beyond the exterior and focus on trying to get them healthy, um, from the inside out.

Dr. Hebert-Magee (35:04):

I would also like to say that, um, you know, there are so many reasons for mistrust, for some people, you know, they're concerned we're trying to, you know, change their beliefs and ideology. You know, when we talked about the COVID-19 vaccine, we had the same level of distrust initially with the HPV vaccine. Um, many parents thought that we were trying to promote promiscuity-

Deon (35:31):

Right.

Dr. Hebert-Magee (35:31):

... and that we wanted their kids to go out and start, you know, being sexually liberated. And I think being able to have those conversations with a trusted pediatrician and say that we just wanna prevent your child from developing certain types of cancers, um, unnecessarily, um, you know, later on in life is what we are intending to do and we know that, you know, every child will not wait until marriage before they actually, um, you know, start engaging in sexual behavior. And, um, so in talking to someone it's important that we dive into their issues, don't be presumptive, don't, you know, say it's a one-size-fit-all, and, you know, just really ask them, you know, what are their concerns and talk to them about it in the most transparent and honest way.

Deon (36:25):

Yeah. And, and, you have such a great, um, approach to how you're explaining this because it's, it, it makes so much sense and you're just breaking it down and so we do appreciate you, you know, coming in, uh, just hear your stories and how you're explaining this because you're, you're absolutely right. No one's the same, there's no cookie-cutter, uh, formula to this. And you, you mentioned, uh, the, the COVID vaccine, uh, and in relation to that, and, you know, these communities, the communities who have had this mistrust, um, is the mistrust of the vaccine itself? Uh, or what's the reason behind that or are they just mistrustful of the healthcare system as a whole and that's the reason why a lot of, um, so to say, marginalized communities are reluctant to get the vaccine?

Dr. Hebert-Magee (37:17):

You know, honestly, I think it's a combination. I think some are distrustful of the system, they're distrustful of the government rollout, um, but I think others actually are distrustful of vaccine components, right? And they're saying, hey, what is this mRNA vaccine? Where did it come from? How were we able to develop this vaccine so quickly? And I think that created a lot of hesitancy.

Diane (37:44):

A- and, you know, there were, we were talking, and we've been talking with our various guests on our podcast about the, uh, the very rapid development of all the new medical technology, the vaccines and what have you. And anymore doctor, you see a whole lot about, you know, some of these folks that are, are hesitant that, kind of, circle the wagon about not wanting to trust a doctor or not wanting to go in. There's more and more about these Tele, Tele, uh, Visits, you know, that you'd pull up on your computer, heck, I don't know that I can do that.

Diane (38:18):

I (laughs), and I'm, you know, I'm, kind of, fairly, you know, efficient with things but that is another barrier that people would say and in some of the, you know, some of these communities, well, I can't get there, I, I don't have, uh, the w- the way to get there, I, I, I don't have anybody that can take me. And like you said, I don't look right, I, maybe I, the doctor will just talk down to me. What, and then, then, then I'm being told that I should do the TeleVisits. I can't do them, that, the, we need options doctor.

Dr. Hebert-Magee (38:51):

Right. I, I completely agree with everything you stated. I think that a lot of people thought that the vaccines did come about too quickly, you know, they were concerned about what was in the vaccines and, you know, this whole, you know, you know, there's been so much advancement when it comes to, uh, genetic-based therapies, right? And, and so now you don't have to give someone a live version of the vaccine. You can use just a simple, you know, um, strand of that genetic code in order to code for a protein that your immune system will recognize as foreign so when it sees it in the future it'll be able to attack. Um, but, you know, I'm, I'm a kid, I, I grew watching The Jetsons.

Diane (39:36):

Mm-hmm.

Dr. Hebert-Magee (39:36):

You know, that was, like, one of my, my favorite cartoons, yeah.

Deon (39:40):

Where are our flying cars?

Dr. Hebert-Magee (39:41):
(laughs).

Diane (39:41):
(laughs). Uh-huh.

Dr. Hebert-Magee (39:43):
Wait, there were flying cars, there were smart watches, um, you know, they had-

Deon (39:47):
They had Rosie.

Diane (39:48):
Mm-hmm.

Dr. Hebert-Magee (39:49):
Yes.

Deon (39:49):
(laughs).

Dr. Hebert-Magee (39:50):
Yes. The robot, right? So, we had robots in homes and, you know, and, and you were able to, um, have, like, virtual conversations and talk to people through a screen-

Deon (40:00):
Mm-hmm.

Diane (40:00):
Yes.

Dr. Hebert-Magee (40:00):
... and it was completely inconceivable. I mean, it was something that we thought was just, you know, very visionary and futuristic, but we would never see any of this in our lifetime. And Rosie, right? We have these smart vacuum cleaners at home-

Diane (40:17):
Hmm.

Deon (40:17):
Yes.

Dr. Hebert-Magee (40:18):

... and, and we have smart watches and we're able to do virtual visits, like you mentioned, where you can look and see someone on a screen who's not in the room with you. And so, I would say that, you know, for a lot of people, you know, things have been moving, um, you know, like, lightning, in leap years. And I would say that, you know, even though telemedicine is a great tool, right, for those who are tech-savvy, those who are able to express themselves, but, you know, a lot of people feel dismissed when they're in the doctor's office. So, God forbid, if you have me on a screen, how would you treat me then?

Dr. Hebert-Magee (40:59):

And as you mentioned, we, all don't have the same nice ambiance in the background. You know, do you have bookshelves behind you? Do you have trophies and artwork? Or do you live, you know, in a situation where you're cohabitating with, you know, seven other people in a two-room apartment, um, and things are very cramped and disheveled, um, you know, you may be in a place that's somewhat dilapidated and will someone look at that environment and judge you-

Diane (41:30):

Yes. Yeah.

Dr. Hebert-Magee (41:31):

... and determine what type of care you should get. What, you know, arm of a clinical trial you should be placed in? You know, are you getting the real vaccine? I mean, it's sad but I had so many phone calls and questions about that. People would say, "Doc, you know, I want the real vaccine. I want what, you know, President Trump have. I want what, you know, Oprah had, give me what Kim Kardashian had, you know, I, I, I don't want that other stuff."

Diane (42:01):

Mm-hmm.

Dr. Hebert-Magee (42:01):

Because they really felt that there was a tiered approach to not only vaccine rollout, but the quality that, you know, that's given. And the reality is that many people go to safety net hospitals, right? You know, they are underinsured- u- uninsured and so they're not going to these, you know, premier, private, you know, hospitals, you know, that smell like Pine-Sol. You know, they're going to places that, um, have limited workforce, um, they don't have a lot of innovation, they're struggling just to serve the populations that they serve and so they realize that there are inequities, I mean, people aren't blind. And so, you know, it's a valid concern that maybe using certain technologies or using certain drugs may be a disadvantage for them.

Deon (42:56):

You mentioned, you know, the fear of being judged, uh, you know, that's a hesitation for some people in certain communities as to why they don't visit the doctor or one reason why they may not have a primary physician. Um, what, what are some other reasons behind that even with there being greater access than ever before?

Dr. Hebert-Magee (43:20):

Right. So, as I mentioned previously, I think that we're creatures of habit. So, I think some people, you know, just have not become accustomed to frequent doctor visits. I think there's also implicit bias, right? So, um, you know, occasionally, you know, I'm driving and, you know, I may see an older person, you know, in front of me and I'm like, oh, it's gonna take forever for them, you know, to, you know, to push the gas pedal once the light changed. But occasionally, you know, this person peels out or if I see a Ferrari that's driving next to me and I look over and I'm like, oh my God, I never expected, you know, to see this, you know, wise-looking woman in here-

Deon (44:01):

Yeah.

Dr. Hebert-Magee (44:01):

... or, you know, I, I, you know, I think that that's a car that I associate with youth. So, I think there is a degree of implicit bias that we all have. I think it's also, um, you know, people have to, or people normally prioritize what's important to them. And, you know, w- we sometimes bring the car to the dealership when the engine is gone. You know, you're supposed to get the oil changed, you're supposed to get the tune-ups. You're not supposed to wait to the last minute, but people have other priorities and if their priority, if, if they are a wage worker, if they're considered to be an unskilled employee, they may be afraid if they take the time to go to the doctor's office, that they may lose their job, right?

Dr. Hebert-Magee (44:45):

We only think about the visit. Let's say, if it's a 20 minute visit, how long does it take them to get there if they're taking public transportation? If they have to take and drop the kids off at the nursery and then take a bus to the opposite side of town and then spend money trying to Uber to get to work on time, you know, the cost of the Uber may be what they make as a day's wage so they may not choose to engage with the healthcare system unless it's absolutely necessary and critical.

Dr. Hebert-Magee (45:18):

And to speak to that point about engaging with the healthcare system, I mean, even I, in this role have been shortsighted. Um, a number of our, um, residents in the region are homebound and so we thought if we can just get a vaccinator, a provider to go to the house and provide them with the vaccine that will, you know, um, help to inoculate this particular sector of the population. So, I had a caller that called and she said, you know, "I want someone, you know, to come out to my house." And I said, "Yes, ma'am." And I interrupted her. And she was like, "No, no, no. I need to ensure that they don't come in a medical vehicle or an ambulance because I live by myself and I'm afraid that someone will come into my house realizing that I'm vulnerable, that they will come in and burglarize me or either assault me so I need for someone to come in a regular car so my neighbors won't know that I'm vulnerable."

Diane (46:26):

Oh my gosh.

Dr. Hebert-Magee (46:26):

And, and, and how do you address that? Because that's something as you, yeah, the s- the sigh. Like, how do you deal with that? And 'cause a person doesn't even feel safe in their own community

because they're old and, you know, they have a disability and they know that if others people see that they won't have pity or empathy, they'll see it as a weakness.

Deon (46:49):

And wanna take advantage of that.

Dr. Hebert-Magee (46:51):

Yeah.

Deon (46:52):

Mm-hmm.

Dr. Hebert-Magee (46:53):

So, there's so many issues, right? And that's why we have to deal with people, you know, as, as people, as an individual and see them for who they are and, you know, and even I, you know, I thought I knew what the issue was. Like, "Yeah, yeah, yeah. We'll get someone to come out to you." And she was like, "No, I mean, that's part of it, but I need for them to be inconspicuous because if people see this medical vehicle, it may make me go into victimization."

Diane (47:21):

And we, and we have to meet people where they are. That's exactly what you've been saying and that's how we start with the medical mistrust gradually and gradually just, kind of, chip away at that doctor, just chip away and then get them into the frame of mind that, I can do this. I need to do this for me, for my family, as an example, and for my community. But sometimes it's gotta be quiet and it takes a few steps, and it might not happen immediately, but at least it starts to happen. And it starts with the conversation like you had with the, the lady who was so concerned. We wouldn't even think of that nor did you.

Deon (48:00):

Right.

Dr. Hebert-Magee (48:01):

Exactly. Exactly. And, um, yeah, it's just having the one-on-one conversations. And unfortunately, um, you know, medicine is a business, um, office visits have been shortened, um, the turnaround time, there's a push for that to get, you know, patients as quickly in and out. And so instead of seeing them, the whole person and addressing, you know, the social and psychological issues that they face and the toll that it has on their health, oftentimes we're only, you know, treating a particular condition or disease and it's unfortunate. So, I'm hopeful that this pandemic has unveiled, you know, festering long, um, inequities that have existed in our society. And now because they've become so visible and we realize the impact that we're going to, you know, um, catch the wave, that we are going to actually be motivated and this is going to serve as a catalyst for us to make the change that's necessary.

Deon (49:14):

Yeah. That the necessary change and the work is starting now, uh, and there are doctors like you who are leading the charge to make that happen. And Dr. Hebert-Magee, we, such an incredible conversation and I know we've learned a lot from you, um, so thank you so much for your time and

your insight and you, you've really opened my eyes to, to a lot of things and how to, uh, be more gentle with people.

Diane (49:44):
Good word. Yes-

Deon (49:45):
Um-

Diane (49:45):
... to be more gentle, yeah.

Deon (49:47):
... and, and, and, you know, just a simple conversation can, you never know where it could lead, it could lead to helping someone, uh, no matter what that, how big or small that assistance is needed, you just never know. Just, just talking to people, it goes a long way, I guess, 'cause I like to talk so here we are (laughs).

Dr. Hebert-Magee (50:07):
No, thank you for having me. And I would say thank you for asking these very provocative questions because sometimes people feel uncomfortable having these discussions but the only way that we'll be able to move the needle and address the issues is discuss what the issues are, so I appreciate both of you for having me today and allowing me to be a part of your platform.

Deon (50:30):
Yes. Let's, let's move that needle together.

Diane (50:33):
Yes indeed.

Deon (50:33):
All of us. Yeah.

Diane (50:33):
Thank you.

Deon (50:33):
Thank you so much.

Dr. Hebert-Magee (50:35):
Let's move it into the arm. Let's move it into the arm (laughs).

Deon (50:36):
Right (laughs). Thank you so much, Dr. Hebert-Magee. And to our listeners, thank you for joining us as well and we hope you enjoyed today's podcast. Until next time.