

II. Vaccination: The General Welfare

COVID Vaccination Is ‘Unlike Tuskegee’: Black Doctors ‘Involved at Every Step’

An Interview with James Hildreth, PhD, MD, President of Meharry Medical College

The following interview was conducted with Dr. James E.K. Hildreth on February 1 by members of the Schiller Institute’s Committee for the Coincidence of Opposites. Dr. Hildreth is President and Chief Executive Officer of Meharry Medical College in Nashville, Tennessee.

Q: Thank you for agreeing to speak with us today, Dr. Hildreth. Could you tell us something about Meharry Medical College?

Hildreth: I’m the 12th President of Meharry Medical College—a role that I’m very proud to have. Meharry Medical College is one of the four HBCU [Historically Black Colleges & Universities] medical



Dr. James E.K. Hildreth

schools in the United States. It’s the oldest and largest independent, predominantly black, healthcare organization in the country.

We’ve been around since 1876. Our founding was after an act of kindness and grace. In 1826, a young, teenage boy named Sam Meharry was driving his salt wagon in the backwoods of Tennessee trying to get home and his wagon broke down. A black family offered him assistance, and he promised them that if they ever

had any means, that his family would do something for African-Americans.

Sure enough, 50 years later, in 1876, Sam Meharry and his four brothers gave a gift of about twenty to thirty thousand dollars—which back then was a lot of



Meharry Medical College



The Peep Holes

Samuel Meharry and his brothers provided the initial funds to open a medical department in 1876 at Central Tennessee College in Nashville. Meharry Medical College, as it is known today, is the oldest and largest independent predominantly black, healthcare organization in the U.S.

money—to establish a medical department at Central Tennessee College, through the United Methodist Church. So, we think of ourselves as having been founded by an act of grace and favor, and our mission has been, since that founding, to give opportunities to people of color to learn the medical arts, to find treatment for their maladies, and we take great pride in that mission, which I embrace fully as its 12th President.

I think we're a very important institution for healthcare. If it wasn't for us, there'd be many fewer black physicians, and our impact on oral health has been significant as well. Just one example: You know, there are six thousand black dentists in the United States, which is only 3% of the total. Meharry Medical College has trained 42% of all the dentists, black dentists, in the country. So, we like to say that our impact on diversity in healthcare has been quite profound, and we embrace that and continue to do that as part of our core mission.

My Involvement in the COVID Vaccine Mobilization

Q: How are you involved in the ongoing [COVID-19] vaccine mobilization? What is your view of the present state of affairs regarding vaccine availability, production, and testing?

Hildreth: I'm excited about where we are with vaccines at the moment. There are two vaccines that have been given EUA [Emergency Use Approval]. I sit on the FDA [Food and Drug Administration] Committee that reviews vaccines for approval, and I was very excited to be a part of that process.

We have two vaccines that represent two companies that have done some really great science to get us here. They're both 95% effective. They both included people with underlying conditions. To a large extent, at least 30% of the participants had some underlying condition. I wish there were more minorities in these two trials, but between African-Americans and Hispanics, it was about a fourth to a third of all the participants—which is not as good as we'd like it to be—but it's pretty good. The vaccines were very effective at preventing disease, hospitalizations, and death, which is what we need them to do. There are some production challenges at the moment, but they're being addressed.

So, I do think that with another vaccine coming

online—[the Johnson & Johnson vaccine] should be getting EUA approval if all goes well by the end of this month—so we'll have three vaccines that are available to use. So, I really suspect that by September we should reach the goal of having three-quarters or two-thirds of us vaccinated, which will allow us to at least dream about or think about going back to a new normal.

So, I think that the vaccine situation is very exciting on the one hand, but on the other hand, the communities that need the vaccines the most, because of hesitancy and [lack of] access are not getting them at the rate that they should be getting them. At one point, here in Tennessee, for example, there was a ten-fold difference in the rate of vaccinations of whites and African-Americans.

Now clearly, if we were going to do this the way to



CC/Christian Emmer

The pioneering Meharry Medical College, in training men and women of color for professions in various fields of medicine, has contributed greatly to the welfare of the entire society.

save as many lives as possible, you would make sure that those who are most vulnerable get the vaccine first, and I think an attempt was done to do that by making sure that seniors were kind of at the top of the list, but you also need to be focused on the most vulnerable populations, which include Hispanic and African-Americans. So, I think that we could do a much better job of prioritizing vaccine recipients.

But, there is a legitimate concern of hesitancy in some communities and access, but this should not be surprising to us because the same factors that have led to health inequities, health disparities, are the same ones that are causing the vaccine distribution to be chal-

lenging. What we need to be focused on is trusted organizations and trusted persons leading these efforts, and that would make a big difference. And, by trusted organizations, I mean churches, institutions like Meharry, and there are others that I can think of—black healthcare professionals should be really involved because people do trust them.

So, I think that with a focus on trust, and trying to deal with the hesitancy, and addressing the distribution challenges, I hope we can get there. But I'm very excited about where we are, compared to where we were just a few months ago. Things are much better.



Courtesy of Dr. Corbett

Dr. Kizzmekia Corbett, a COVID vaccine research fellow at the National Institutes of Health.

who on a routine basis review the data from trials to make sure that the participants are protected.

Then after all that, we have an FDA committee which reviews all the data to make a final decision/recommendation to the FDA that the vaccines are safe. What people need to know is that people of color, African-Americans in particular, have been involved in every stage of the vaccine development.

In fact, some of the fundamental science that was the underpinning for the mRNA vaccines was done by a brilliant black woman at The National Institutes of Health. Her name is Dr. Kizzmekia Corbett. Many

people don't know that a black woman is right there at the center of all of this. Her research was a fundamental part of it. There have been African-Americans on the data safety monitoring boards that review all of the data, all of the data from Pfizer, and all of the data from Moderna. There's a group of individuals—experts independent of the companies—who get to see the data, sometimes on a weekly basis, to make sure that people are protected.

Then after all that, the data comes to the FDA where a committee called the Vaccines and Related Biological Products Committee (VRBPAC) reviews the data one last time to make recommendations to the FDA. Myself and one of my colleagues, Dr. Avida Fuller, who's a professor at the University of Michigan—an African-American woman—the two of us sit on that committee, and we've been involved.

So, people need to know that we—unlike Tuskegee and other things like Henrietta Lacks, and all the other things we read about—we have been involved in vaccine development in fundamental ways that could not have even been imagined just a few years ago. And so, that by itself does not guarantee that they're safe, but people need to know that [there are] folks, like myself, who are deeply committed to making sure we protect our communities. We've been involved at every step, and hopefully that gives people some additional level of comfort about the vaccine.

And about the vaccines themselves, I've heard all

Vaccine Safety and Vaccine Hesitation

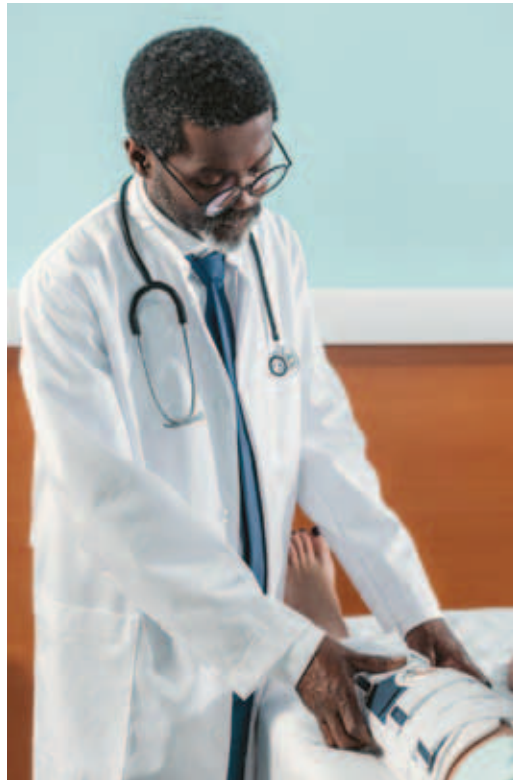
Q: There has been a lot of concern and fear regarding the vaccines. Many people have been comparing the mass issuance of vaccines with the infamous Tuskegee Syphilis Experiment conducted from 1932 to 1972. Is there any legitimacy to these concerns?

Hildreth: I think the first thing I would say is that we have to accept and acknowledge that people of color have every right to be hesitant and to have some level of mistrust when it comes to medical research, vaccines, etc.

In fact, going all the way back to 1619, there have been atrocities visited on black bodies supposedly for medical research that we don't have to hear about or won't have to know about. So, in no way can we dismiss or belittle or brush aside the concerns that people of color have. They're legitimate; they're well-founded.

I have to say that the vaccine development was nothing like Tuskegee, and one of the things that people need to know is that because of Tuskegee, medical research involving human beings has never been the same. As a result of Tuskegee, there was a national commission put together, [the National Bioethics Advisory Commission,] by President Bill Clinton. We have Informed Consent now as a routine part of clinical studies. We have data safety monitoring boards: these are an independent group of experts and patient advocates,

kinds of misinformation which can be dispelled easily. There are no microchips in the vaccines to track people. If they're worried about that, they should get rid of their cellphones. That's where the tracking really occurs. There's no mercury or heavy metals. There are no animal products or cellular products. These two vaccines are chemically defined. They have mRNA in them, which is a manufactured chemical. They have inorganic salts, some lipids, sucrose, and water. That's it. That's all that's in that vial that's getting injected into your arm. So all these things about "microchips to trace me," heavy metals like mercury—none of those things are true. And so hopefully that would get some added insurance that the vaccines can be taken without doing harm.



CC/Igor Vetushko

A physician adjusts a patient's leg brace.

vested it in public health and preventive medicine, the results would be quite profound. So, I totally agree with the idea of changing our focus to be more on public health and prevention rather than being reactive and taking care of people when they're really sick. We do a really good job of that, mind you, but we could also do a really good job of keeping people healthy in the first place.

Now, we all hear about the health disparities and health inequities, but it turns out that healthcare only accounts for a small fraction of our overall health and well-being. According to Kaiser and some other organizations, it's 10-15%. The rest of it is what you do, where you live, and how much you know in terms of your education level. Those things account for

more of our health than healthcare and access to it.

Structural racism finds its way into all of the discussions we have about health. It is even responsible for the fact that only 3% of dentists are black, less than 5% of physicians are African-American, and those are really important things when you think about healthcare and access to it. We need more people who look like us sitting on the other side of the table. But because of implicit bias, economic factors, and some other things, we find ourselves less healthy, sometimes by wide margins, than the majority of the population.

So, I do believe, and I totally agree with the concept that we need to invest more in public health, especially during childhood, and the return on that investment would be quite profound; and we need as a country now to start looking at that, because what the pandemic has done—for the whole world to see—is [to show] the chasm in the health status of people of color...

You know, we train large numbers of healthcare providers of color—dentists, doctors, researchers—and part of our history is that we have a wealth gap, even among those professionals. Because at one point in our history, if you were a physician, [because of racial dis-

'Sick Care' vs. 'Well Care'

Q: [Former Surgeon General] Dr. Joycelyn Elders has talked about expanding public health in the United States by rapidly recruiting young people to assist/work as community health workers. How can medical schools and other institutions be utilized in that kind of public action?

Hildreth: I think it's a really important thing for people to know that 17 or 18% of our Gross National Product is spent on healthcare. \$3.5 trillion! I mean, just think about that. If we took what we spent on healthcare, and set it apart, it would be the fifth-largest economy on the planet, right behind Germany.

And yet, we're not even in the top 10 of healthy nations after spending trillions of dollars each year! And one of the reasons for that is that our system of healthcare is really a system of "sick care." We have a system that takes care of you when you're sick, sometimes not very well, but does very little to keep people healthy in the first place.

So, if we just took 10% of that \$3.5 trillion, and in-



USN/Brian A. Goyak

A volunteer dentist from the Pre-Dental Society at the University of California San Diego extracts a tooth from a patient in Lima, Peru.

crimination—ed.] you couldn't get privileges at hospitals, you couldn't buy a house in certain neighborhoods—and houses were a way to accumulate wealth. So, even the professions that traditionally allowed families to begin to accumulate wealth were not able to do so, because of redlining and some other things. So, my point is that a lot of what we see in 2021, that's been revealed by COVID-19, are the results of years of oppression that continue to be a challenge to our society.

And, you know, when people ... see what happened with George Floyd, and other things, they always say, "Well, this is not who we are." Maybe it's exactly who we are, because it keeps happening over and over again. And so, as Maya Angelou would say, "When people show you who they are, perhaps you should believe them." And what we've shown the world is, we say all the right things, and we have all these great platitudes about how we reformed as a nation and all this, but we've got a lot of work to do to fully realize the potential we represent as a country. And, from my perspective, one of the main issues we have to tackle is racism. And, that's just part of the reality we're in right now.

Getting Youth Involved in Public Health

Q: What difference can young people make in educating others on social distancing and other public health measures together with healthcare professionals?

Hildreth: I love the idea of getting young people

involved in this, because they represent future leaders of public health, medicine, etc. So, I love the idea of getting young people involved in specific ways, and, you know, I'm so proud of our students at Meharry who've been on the front-lines of testing, of making sure the vaccine can get to our elderly.

And, a lot of our most creative contributions, to whatever domain we're in, come when we're young. I mean, most Nobel laureates did the work to get their prizes in their late 20s and 30s. So, I'm all for getting young people involved. We need their energies, and we need their ideas. But most importantly, we're going to be turning over this world to them, or this country to them, and I think that we owe it to them to begin to take ownership of some of these problems.

Quite honestly, I've often talked about trusted messengers, and some of these young people can be just that in terms of interacting with their communities. So, I love that idea. I think it's a great idea, and I wish some of that \$3.5 trillion could be designated to programs like that. That's what I was referring to. The resources are there, we just need to invest them differently. And that would be a great way to change some of our investments in our future.

Staying Ahead of Variants

Q: What is the difference between a pandemic and an epidemic? Why should we be concerned about people in Botswana or South Africa, Iraq or other countries getting the virus? How will it affect us?

Hildreth: Pandemics are by definition a global epidemic—it's an epidemic that's occurring all at once around the globe. That's the difference between an epidemic and a pandemic. And please keep in mind that the reason why COVID-19 spreads so rapidly just has to do with the mobility of us as human beings around the globe. *We* are the vector for this virus. Unlike SARS and MERS in 2003 and 2012, you only got the virus by coming into contact with an infected animal; they were the vectors. In this case, *we* are the vectors.

So—as long as human beings travel freely around the world—in terms of a pandemic, none of us is safe until everyone on the planet is safe, which means that we as a nation need to be concerned about what's happening in Botswana, South Africa, Canada, and the



USANG/Andrew Jackson



VoA

Dr. Hildreth: “We need to be concerned about what’s happening in other places, including the African continent, and beyond.” Two National Guard medical specialists prepare doses of the COVID-19 vaccine during a drive to vaccinate Hawaiian National Guardsmen (left), while an Israeli senior citizen receives a COVID-19 vaccination (right).

U.K., because the variants that are arising there can hitch a ride with a person and make their way to our country.

Or, if the virus is replicating out of control in the United States, those same variants could arise here, because every time this virus replicates, there’s a small but definitive chance that a mutation will occur, because mutations occur when the virus is dividing or replicating. And so, to the extent that we don’t control the virus very well, we’re setting ourselves up to have our own variants, and to be honest with you, the United States has not been looking for the variants like they’ve been looking for them in other countries.

So, as far as we know, there might be some variants here in the United States that might be as challenging or troubling as the ones being found in other places. Thankfully now, the CDC [Centers for Disease Control and Prevention] is working with organizations to begin sequencing many of the viruses that are being isolated from patients. So, hopefully, we’ll have a better grip on it.

But the point is—because the world is such a small place now because of international travel, and because we’re carrying the virus

with us as we go from place to place—we need to be concerned about what’s happening in other places, including the African continent, and beyond. And if we don’t do a better job of controlling the virus here, we might have our own variants to worry about.

Deploying Vaccines to the Poorer Nations

What is the United States’ role in deploying vaccines to nations that are poor or cannot produce their own vaccine?

Hildreth: My own personal view is that the United States should identify companies with the capacity to



CGTN

Patients in a hospital COVID ward in West Africa, March 2020.

produce the vaccines, and work out a deal with the drug companies that developed them—with our money by the way—with taxpayer contributions. These drug companies got billions of dollars of support from the United States to make these vaccines. So, we should have some say because taxpayer dollars were invested in producing them.

So, you may have read or heard or you've seen the stories that Merck has agreed to produce the vaccines that were developed by Pfizer, and Moderna, because Merck is a huge drug company—they've got a lot of capacity—so they're offering to help manufacture the vaccines. So, I think we need to look for other companies with capacity for production, line them all up, make sure we can meet the standards that are needed, and make the vaccines, and give them—literally give them—to the countries that need them because some countries cannot afford to pay for these vaccines. And yet, we've got to make sure they get them.

I was also disturbed to hear, for example, that Israel sort of cut.... I wouldn't say cut the line, but Israel paid a premium to make sure they got the vaccines first. They're one of the first countries to get the vaccine, and, apparently, they're able to do that by paying the premium. We cannot have a system where the rich countries can buy up all the vaccines beyond the capacity needed and have the other countries waiting for years, because what I've read and seen is that it might take as long as two or three years for some of the other countries to get the vaccine. That to me seems like it should be unacceptable. It should be unacceptable to everyone who cares about humanity. Period. That we need to help the countries that need the vaccines who cannot buy them; that would be my recommendation.

COVID-19 Compared to Past Global Pandemics

Q: How would you characterize the current COVID-19 situation in comparison to past global

pandemics, such as the Spanish Flu of 1918?

Hildreth: Well, what's extraordinary to me is that we are approaching the number of deaths from COVID-19, in the United States, to the number of deaths we had in 1918 from the Flu pandemic.

And if you think about comparing and contrasting the technologies available to us, both in terms of medical ... they didn't have ventilators or any of those things in 1918. They did not have Remdesivir, or steroids, or any of those kinds of drugs. So, how is it possible that



National Museum of Health and Medicine

Dr. Hildreth: "How is it possible that we could be approaching the number of deaths in 2021 from a less virulent virus [COVID-19], than what we saw in 1918?" Here, soldiers ill with the Spanish flu in a hospital ward at Camp Funston, Kansas in 1918.

we could be approaching the same number of deaths in 2021 from a less virulent virus than what we saw in 1918?

It all comes down to a ... it's almost as if we're so caught up about self, and unwilling to do things that would benefit the larger community. Because, think about it—wearing a mask, you do it to protect yourself, but you also do it as an act of protecting your community, the people around you. Same thing with a vaccine. If you take the vaccine, you are helping us collectively, as a community, become immune to it [the virus]. So, it's almost an act of self-love, but it's also an act of love for the rest of the people.

And, to me, what we're seeing is the politicization of science, the polarization of our nation to the point that something like a public health crisis can become a political football, and that's a very dangerous thing. And, to me, that's why we're seeing the numbers we're seeing. There's no way in the world that the United States should be 4% of the population of the globe, but 25% of the deaths from COVID-19. Just think about that. We're only 4.6% of all the people on the planet, but we represent 25% of the people who [have] died. It's ... just unthinkable, right? And it just says to me we should really be careful and think about the people we elect to lead us.

This is a leadership issue. Let's be clear about it. We have two of the most premier organizations—I would say the most premier organizations on the planet—the CDC and the FDA, that should be preeminent in leading us through this....

A New Global Healthcare Platform

Q: In your view, how can we emerge from this pandemic in a situation where we can avoid deadly pandemics in the future? What would be the global public health platform that you would envision?

Hildreth: ... So, as we said earlier, pandemics are global problems, and viruses do not respect borders. They don't respect continental borders. They don't respect safe borders, county borders, or city borders. The only way to fight them ... [is that] it has to be collaborative effort.

Because, for example, here in Nashville, we could do a fantastic job of trying to control the virus, but if our neighboring municipalities don't do that—because people are traveling back and forth—we'd find all of our work undone. So, all I'm trying to say is that it's going to take a collaborative effort to deal with this. What we really need is we need a team of scientists—they're all from around the globe—whose only job it is to monitor for the outbreaks of potentially pandemic viruses.

And by the way, we had such a thing, but the previous administration cancelled the funding for it.... So, some of the things that needed to be done had been done, but they were dismissed for political, non-scientific reasons, and that is the most dangerous thing you can have happen. When politics subsume science, and you're talking about virus ... viruses don't know—

they're agnostic to gender, to race, to politics, to geography. They're just looking for a warm body with the right receptors. It's going to infect that body and do what it does.

So until we fully embrace this notion that some things have to be non-political—they just have to be—we're gonna be in deep trouble. And I'm really praying and hoping that we as a nation, and a world, can come to realize that, that there are going to be some things we have to deal with in a strictly non-political fashion because the circumstance or the challenge demands that we do so.

I, as a scientist, I'm just exhilarated that in ten months, science produced two vaccines, in the time that it would normally take years, several years. I mean, vaccines take years to produce. The fastest one was 4 years [for Ebola]. The longest one took 100 years [for smallpox]. So, to do this in ten months is truly extraordinary!

And—I don't want people to miss out on this—that if the scientific communities' model of collaboration and interaction had been exemplified by the politicians and our leaders, it would have been a totally different outcome. Nothing has excited me more than to witness the way that thousands of scientists literally around the world dropped what they were doing to focus on trying to find an answer for this problem. You know, we're interacting with scientists in Brazil, and other places. Those kinds of international collaborations are seen all over the place. If only our leaders could have had that same spirit of collaboration and working together, this would have had a different outcome. So, that's one lesson I think that the politicians should have taken from the scientists on this one.

My Life in Medicine

Q: What personally motivated you to get involved in medicine? How did your personal experiences shape the person you are today?

Hildreth: I grew up in a small town in Arkansas, Camden. It's one of those towns where there's a railroad track that separated the White community from the Black community. And, when I was 11 years old ... actually, I was 10 years old when my dad got sick, but he died when I was 11 in 1968. That was in January.

Four months later, on April the 4th, 6:01 p.m., in Memphis, Tennessee, Martin Luther King, Jr. was as-

sassinated. He had become my superhero at age 11. I just thought he was. . . . So, it made me really angry because my dad got almost no medical attention, because we were poor and black. And, I had figured that out. There's a hospital over here. There are doctors in the hospital. Why can't my dad get [treatment]? My mother prayed me out of my anger and challenged me to do something about it, so I made the decision I was going to become a doctor so that no other young person would have to go through what I went through.

The problem was that I'd never seen a black doctor, didn't know you could be a doctor if you were black, and had no role models. But, my mother's the one who . . . Let me put it this way: there's a song that's sung by a group called Sweet Honey in the Rock—you might know them. They have a song called, "There Were No Mirrors in My Nana's House." So, I didn't know that my nose was too big, my hair was too nappy, and my skin was too dark, to do this.

My mother took down the figurative mirrors in the house, and I decided I was going to become a doctor. I started reading books about medicine and doctors at age 13, and it turns out that back then they were ranking universities as to your chances of getting into medical school if you were pre-med there. There was one school that was head and shoulders above all the rest, and that was Harvard.

So, at age 13, my life's work became getting into Harvard. I did Boys Scouts, had two jobs, played sports, [was] superintendent of the Sunday School—everything I could do to make myself attractive to Harvard. And, sure enough, in 1975, I got admitted to Harvard, Yale, Princeton, Brown, Stanford, [and] a few other schools all with scholarships. But because my research had said, "Harvard," that's where I went. So, I was a pre-med at Harvard, and the other thing that really changed my trajectory was . . . I took a job at the medical school changing the cages for the immunology researchers. My job was to take care of about 1,000 mice, and I changed their bedding and food twice a week.

Turns out that one of the professors there was also from Arkansas, and at the time there were very few Arkansans at Harvard, and when he found out I was from Arkansas—even though he was white and I was black—he took an interest in me and ended up convincing me that immunology was what I should do, even as a Chemistry major.

Then, I was encouraged to apply for a Rhodes Scholarship. I got a Rhodes Scholarship and went to Oxford to get a PhD. I was the first African-American from Arkansas to be a Rhodes Scholar, and I came back to Johns Hopkins for medical school, and was going to be a transplant surgeon because transplant surgeons need to understand and use immunology to make sure their organs are not rejected.

But the first patient I took care of as a medical student—literally in my first rotation I think—was a young black woman who had just given birth to a baby. They were both HIV-positive. There was absolutely nothing we could do for them, except watch them die. I knew that this was going to be an important problem for immunologists to solve. I also kind of instinctively knew that perhaps

this would be something that affected people who looked like me. So, I changed my plan. Instead of becoming a transplant surgeon, I went into infectious diseases, specializing in HIV.

So imagine someone who got started in medicine because of a health disparity now leading an organization whose purpose it is to make sure they get eliminated. So, as far as I'm concerned, it's like my life has come full circle. And, this will be my last job, and I'm very excited about what we're doing here. But, that's why I came to Meharry. That's why I got into medicine. And so, that's why I'm determined to make sure that this pandemic does not undo what limited progress we've made. We've got to save our communities, and I'm hoping that many young people will be inspired by what they're witnessing, to want to make the same kind of decision I made because of what happened to my dad.



Dr. James Hildreth: "I got started in medicine because of a health disparity." I am "now leading an organization whose purpose it is to make sure they get eliminated."

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