Philanthropy Profile

A Conversation with Laura Gerald, President of the Kate B. Reynolds Charitable Trust

Interview conducted by Kaitlin Ugolik Phillips

Current issues of trust between health care institutions and communities are rooted in generations of marginalizing behavior and system failures. In this interview, Kate B. Reynolds Charitable Trust President Laura Gerald emphasizes the hard truths about why trust is lacking and what must be done to build it.

Introduction

The COVID-19 pandemic brought skepticism, fear, and distrust of health institutions to the forefront in new and concerning ways. As debates about masks, distancing measures, and vaccines mounted, many clinicians, administrators, and public health professionals began to ask what had caused such a lack of trust in their decisions and expertise. But for those who have studied and experienced the inequitable impact of our health systems for years, there may be a much more important question to ask: Are we trustworthy?

In an interview with the *North Carolina Medical Journal,* the Kate B. Reynolds Charitable Trust's president, **Laura Gerald, MD, MPH,** examines the history of medical mistrust in North Carolina and talks about what it takes for a health institution to earn the trust of everyone in its community.

NCMJ: We often hear the questioned asked in the health community: "Why is there so little trust?" How do you respond to this question?

Laura Gerald: *If we're going to ask ourselves how we got to this place of lack of trust, we have to be very honest about our history. We have seen, time and time again, actions by health institutions that do not take into account the harm that they have caused or the needs and experiences of communities that have been marginalized. Most people are familiar with the Tuskegee Study [1], but right here in North Carolina, people were forcibly sterilized through the 1950s at the express recommendation of public health officials [2]. In 2011 and 2012, I chaired the Governor's Task Force to Determine the Method of Compensation for Victims of North Carolina's Eugenics Board, and I heard firsthand how victims went to health institutions for care and treatment and instead were forced into sterilization without proper consent. That specific practice does not continue, but unfortunately many communities have current lived experience with implicit bias.*

When we look at how we got to a maternal mortality rate for Black women that is three times that of White women, we can understand the realistic and reasonable fear that Black and Brown communities have about what they will encounter with a health institution [3]. We as institutions need to address our own behavior, and I don't know that it is addressed nearly as often as we want communities to change their behaviors.

NCMJ: How can health institutions in North Carolina in particular work toward changing those behaviors?

Laura Gerald: *We cannot disregard the history of our health institutions, including the closure of medical schools that trained Black doctors. The first four-year medical institution in the United States, at what is now known as Shaw University in Raleigh, opened in 1882 [4]. It was shut down in 1918. We know Black physicians were excluded from admitting privileges and the North Carolina Medical Society, leading to the*

Electronically published May 1, 2023.

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N C Med J. 2022;84(3):185-187. ©2023 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2023/84317

formation of the Old North State Medical Society, a professional association for Black doctors. Research shows the importance of culturally and racially concordant care [5]; yet, how many fewer Black doctors do we have in North Carolina today because health institutions have not prioritized training physicians of color? We see those same disparities and the history of discrimination reflected in the current workforce. When you talk to people about their trust in their own doctor, that tends to be fairly high [6]. But if you ask about trust in the institution, there are still concerns about quality and implicit bias [7].

NCMJ: What does a trustworthy health institution look like?

Laura Gerald: *A trustworthy institution is one that is truthful not only about the role that patients play in the outcomes they see, but truthful about the role it plays in patient outcomes and is committed to improving the conditions the institution has systematically contributed to and perpetuated. A trustworthy institution is one that honors and humanizes the people it treats. Health care delivery institutions need to dig deeper around patient outcomes and look at the true determinants of those outcomes, such as the conditions where patients are living and working. Who is included in food systems? Does the built environment support opportunities for active living in all neighborhoods? Are there economic opportunities for people? Is there a quality education system for children? Policies and practices underly the social determinants of health, and those policies and practices impact people's ability to live healthy lives. As a key stakeholder and pillar of the community, health care institutions have a role to play in shifting those systems. There are many things health institutions can do to help their community, and not all of them are in the "lane" of patient education and treatment. People are not broken, systems are, and that's one of the things we try to keep in mind at the Trust. And you cannot do this work without the impacted people at the table. They have experiences and potential solutions that need to be addressed, so we try to start there. You can't be in partnership with people you don't know.*

NCMJ: How have your personal and professional experiences guided your work in this area?

Laura Gerald: *I've been on both sides: I've been a patient, and I've also practiced medicine in my home community in Robeson County. As a patient, I've had mixed experiences. Even with my background as a Hopkins-trained doctor, there are times when I haven't felt heard, or my symptoms were disregarded by health care providers. From a professional perspective I understand the pressures on volume, but while in practice, I made an effort to ensure I humanized and listened to every patient, serving as a thought partner and not just focusing on patient "compliance." We often attribute health outcomes to personal behavior, but we're rarely thinking about what opportunities patients have, where they live, or their access to healthy food, a quality education system, or economic opportunity. When we're in our one-on-one encounters with patients, we need to think about those outside issues. We all must combat stereotypes and biases every day in our interactions.*

NCMJ: How can we measure and evaluate efforts to build equity and trust?

Laura Gerald: *I think of equity as both a journey and an outcome. One of the reasons we don't have the answer is because we have never achieved the outcomes we want to achieve; we've never eliminated health disparities; we've never eliminated wealth and income disparities or educational disparities. We have engaged in practices that have reduced those, but there is always backlash. For example, we enact laws for voter equality, and then we must contend with new laws that target Black people to infringe on those rights.*

We know how to enact policies that help people, and we know how to measure that. Where there is a will, there is a way. We have to stop being afraid that the progress of one group means the retraction of another group. If we can just stay focused and keep on course, we will achieve what we are seeking to achieve.

NCMJ: What is the role of organizations like yours in building, or rebuilding, trust?

Laura Gerald: *I want to start by acknowledging the history of the Trust. We just celebrated our 75th year, and one thing we did for our anniversary was some truth-telling about our founder, and how we came to accumulate such wealth within the foundation. We talked about the history of slavery, how wealth was accumulated on the backs of enslaved persons, and generated from tobacco, something that has caused tremendous health harm even as we were*

working to improve health. We have committed to not only acknowledging our past, and apologizing for it, but also to doing better in the future. We have divested from tobacco and we have committed $100 million of our endowment toward investments that increase economic opportunity in underresourced communities in the state. These changes in our investments are in addition to the approximately $20 million the Trust makes in grants each year to improve the health and quality of life of North Carolinians with low incomes. We specifically focus on helping communities of color and rural communities thrive because the data shows us that long-standing health, economic, and education disparities exist by race and place.

In addition to supporting health care institutions, we are trying to support the building of relationships between health care systems and community. We are investing in grassroots groups and organizations led by people of color to empower them to lead the change they want to see and to participate in critical conversations with health institutions that have often not met their needs in the past. In a value-based care environment, where we're being held more accountable to the actual patient, I think we will see health care systems that are interested in authentic relationships with community-based organizations. We want both grassroots organizations and health care delivery systems to have the capacity to be in authentic partnership with each other.

I would say to other institutions: If you want to build trust, you must be trustworthy. We have confidence in health care institutions' ability to commit to a future that frankly looks different than our past. NCMJ.

References

1. The Syphilis Study at Tuskegee Timeline. CDC.gov. Last reviewed December 5, 2022. Accessed March 22, 2023. https://www.cdc.gov/tuskegee/timeline.htm
2. Rose J. A Brutal Chapter In North Carolina's Eugenics Past. NPR.org. Published December 28, 2011. Accessed March 22, 2023. https://www.npr.org/2011/12/28/144375339/a-brutal-chapter-in-north-carolinas-eugenics-past
3. Working Together to Reduce Black Maternal Mortality: Racial Disparities Exist. CDC.gov. Published April 6, 202. Accessed March 22, 2023. https://www.cdc.gov/healthequity/features/maternal-mortality/index.html#:~:text=Racial%20Disparities%20Exist,structural%20racism%2C%20and%20implicit%20bias
4. The First Four-Year Medical School in the United States. Shawu.edu. Accessed March 22, 2023. https://www.shawu.edu/The_First_Four-Year_Medical_School_in_the_United_States.aspx
5. McDade W. Racially Concordant Care. Presented to Health Resources and Services Administration, 2021. ACGME. Accessed March 22, 2023. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/infant-mortality/meetings/racially-concordant-care-william-mcdade.pdf
6. Finnegan J. Survey finds more than 9 in 10 people say doctors are the most trusted professionals. *Fierce Healthcare.* Published May 21, 2019. Accessed March 22, 2023. https://www.fiercehealthcare.com/practices/survey-finds-over-9-10-people-say-doctors-are-most-trusted-professionals
7. Sausser L. Public Health Agencies Try to Restore Trust as They Fight Misinformation. *Kaiser Health News.* Published January 4, 2023. Accessed March 22, 2023. https://khn.org/news/article/public-health-agencies-try-to-restore-trust-as-they-fight-misinformation/