and fatigue, which reduced the sense of isolation and normalised conversations about mental health.

To effectively support health-care workers—the greatest assets of our health-care systems—we must understand their challenges and needs. Burnout and other forms of work-related psychological distress are unavoidable occupational health issues. By acknowledging the commonality of psychological distress related to caring for patients with COVID-19, we can destigmatise work-related mental health issues and appropriately attend to the mental health needs of all health-care workers affected by the pandemic. Finally, we hope that the COVID-19 pandemic will prompt a redefinition of essential support workers, with recognition of the contribution of all health-care workers and appropriate education, protection, and compensation.

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An issue of trust—vaccinating Black patients against COVID-19

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2020 has brought unprecedented challenges to the field of medicine. At the forefront of it all is COVID-19. This disease has paralysed the globe, leading to closure of schools, religious establishments, and businesses worldwide. With the winter season upon us and hospitalisations reaching all-time highs, our level of concern for this disease rises. The estimated number of lives that will be lost and affected is unfathomable. If this holds true, achieving herd immunity must be a global priority, which in turn might mandate an effective vaccine deployment strategy. With the roll out of two vaccines achieving over 90% efficacy, an obvious question must now be answered. Which populations should be prioritised for immunisation?

Other than health-care workers, who are already being vaccinated, two groups should be considered for early administration: patients who are immunocompromised, and who are at highest risk of developing severe or critical COVID-19 infection and dying from this disease; and those populations which are disproportionately affected by COVID-19 from a health and socioeconomic standpoint, who need to be prioritised due to the devastation on their vulnerable communities. These vulnerable communities tend to be areas with a higher prevalence of Black, Hispanic, and Native American individuals. It is not that one of these groups must be prioritised above the other, but rather both should be considered at increased risk when compared with the general public.

A study done by the Center for Public Affairs at the University of Chicago (Chicago, IL, USA) reported that 211 (20%) of 1056 individuals surveyed said they do not plan to get a coronavirus vaccine when one is available.[1] 169 (16%) of white individuals said they would not get the vaccine compared with 422 (40%) of Black participants. This discrepancy between Black and white patients might reflect a general lack of trust that some Black patients have towards the health-care infrastructure in which so

few medical providers look like them. It is also important to realise that while Black physicians are physicians, they remain Black. Our white coats do not eradicate our own concerns of mistreatment and disparity that drove many of us to pursue a career in this field. Even among doctors, vaccine hesitancy exists. This apprehension is of particular importance to acknowledge because many individuals in the Black community will turn to physicians who look like them for guidance regarding the COVID-19 vaccines.

The Black community is no stranger to the concept of immunisation. In fact, some would consider this group pioneers of the process. In the early 1700s, approximately 75 years before Edward Jenner's famous Smallpox inoculation, a slave given the name Onesimus reportedly described the African practice of variolation in which bodily fluids (eg, pus) from an individual presumed to be infected would be introduced into an intentional wound of a healthy person as a means of building immunity.[2] This practice subsequently helped save countless lives in the US colonies during the era of smallpox.

In clinical practice, we sometimes encounter Black patients who express a lack of trust in the health-care system, based on a presupposition of malintent. These fears are justified by a long history of medical experimentation done on their ancestors with stories that have been passed down from one generation to the next. Although the most notable of these is The US Public Health Service Syphilis Study at Tuskegee,[3] more pertinent to our current COVID-19 situation is the history of vaccinations during the American era of slavery. In her book *Medical Apartheid*, Harriet Washington explains how slave owners made their slaves receive vaccinations before the owner's family, not to protect the slaves but rather to ensure the vaccines would be safe for the owners and their relatives.[4] Washington goes on to detail about how a famous politician claimed he had administered vaccinations to his family members as a ruse of demonstrating leadership to the nation when in truth he had administered the vaccination to his slaves who were, for all intents and purposes, being used as guinea pigs.

This history of transgressions sometimes translates to great skepticism for medical advances among the Black community. When our leaders in health care recommend that the severe acute respiratory syndrome coronavirus 2 vaccine be administered in mass first to our disproportionately affected communities, this could lead some to believe they are further being tested upon before releasing the vaccine to the general population. As medical practitioners, understanding the rigour and various phases of drug trials, we of course do not believe this to be the case. However, we acknowledge the scepticism as a legitimate concern incited by history.

So, the question remains: how do we achieve herd immunity? First, we do not pressure any individual to be vaccinated. Instead, we focus on educating the population at large. Social media has made this easier than ever, and leaders in the community and health care must leverage these tools to properly advise society pertaining to COVID immunisation. Furthermore, it is every physician's responsibility to counsel each patient on this topic while addressing their patients' concerns. Novel vaccination technologies utilising messenger RNA and adenoviral transgene delivery, not previously used in the general population, will generate many questions that must be answered. It will take time, but trust is earned with patience and full disclosure.

Perhaps most important, however, is that we properly convey the truth that these vaccines will not be tested on vulnerable populations, but rather safely administered for their benefit. To emphasise this, such populations might desire to first witness the safe administration of vaccines on a highly visible, but not abundant, number of societal leaders, including health-care professionals and politicians. This transparency of vaccination is a short-term solution in a time of crisis; a plaster over a deep wound of mistrust. Ultimately, what is needed within the medical profession is a broad profile of health-care workers that vulnerable populations can trust, not having to constantly question their motives. A profile of clinicians who they believe represent their best interests. A profile of clinicians as diverse as they are, who come from neighborhoods like theirs and understand their experiences.

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