In Clinical Care, What Will Amazon Deliver?

Economics aside, there’s an atavistic level on which Amazon’s entry into primary care gives me pause. Amazon came to clinical care intending to reinvent the field with technology. I can’t help fearing that the company’s staggering wealth will give it the power to dictate how things will be. I’m not interested in living in a world that Amazon makes. Its priorities are not my priorities, and I’d rather not have Amazon telling me how primary care is going to work.

Amazon Care’s very existence is a symptom of the misaligned incentives and yawning gaps in U.S. health care. It’s a long way from dropping goods on my doorstep to managing the complexity that even patients with the most straightforward needs bring to primary care. It’s this realization that gives me hope — hope that the messiness of human lives can challenge any easy, limited solution. Hope that human beings, at the end of the day, need human doctors.

Disclosure forms provided by the author are available at NEJM.org.

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This article was published on December 18, 2021, at NEJM.org.


DOI: 10.1056/NEJMp2113702
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Covid-19 Vaccination in American Indians and Alaska Natives — Lessons from Effective Community Responses

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From the beginning of the Covid-19 vaccination campaign in the United States, the non-Hispanic American Indian and Alaska Native (AI/AN) population has continuously had the highest first-dose and full vaccination rates of any racial or ethnic group. This trend is especially important given that AI/AN communities have been disproportionately affected by Covid-19 and by ongoing discrimination throughout the health care system. But since the early days of the pandemic, AI/AN communities have worked to protect the health and well-being of their members, including by adapting community mitigation and vaccination strategies to their diverse cultures.

In the United States, 9.7 million people (2.9% of the population) identify as AI/AN alone or in combination with other races. There are 574 federally recognized tribes located in 35 states. AI/AN lands, which are sovereign territories, extend over 100 mil-
lion acres, including 44 million acres in Alaska.

The Indian Health Service (IHS) serves 2.56 million people in AI/AN communities. The agency received Covid-19 vaccine doses soon after emergency use authorizations were granted and shipped allotments swiftly by means of its national distribution system to designated “receiving facilities” (tribal health programs and urban Indian organizations) in all IHS areas. By the end of November 2021, the IHS had distributed 2.4 million vaccine doses and administered 1.9 million. In Alaska, which is home to 229 federally recognized tribes and villages, the Alaska Native Health Board — the statewide voice for Alaska Native health issues — partnered with the state government to receive vaccine allocations. Provid-

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Percent of Persons Who Received Covid-19 Vaccines, According to Race and Ethnic Group.

Adapted from the Centers for Disease Control and Prevention (CDC). Information on race and ethnic group was available for only 70.0% of persons who received at least one dose and 73.3% of fully vaccinated persons. On August 31, 2021, the CDC updated its algorithm for assigning a race or ethnic group category for vaccine recipients to align with U.S. Census Bureau classifications. All racial and ethnic categories other than Hispanic or Latinx are non-Hispanic.
ing vaccine access through either the IHS or state partnerships therefore appears to have been an effective strategy.

According to the Centers for Disease Control and Prevention (CDC), which publishes available vaccination data according to race and ethnic group, non-Hispanic AI/ANs have led the United States in rates of first-dose and full vaccination (see graph). Early in the national vaccination campaign, vaccination rates among AI/ANs lifted off from baseline weeks ahead of rates among other racial and ethnic groups. By September 2021, vaccination rates among non-Hispanic AI/ANs were about 14% higher than rates among non-Hispanic White persons for first-dose vaccination and 8% higher for full vaccination. Higher-than-average vaccination rates in AI/AN populations have been corroborated by state and county data.

Multiple drivers have probably contributed to relatively high rates of vaccine uptake in these communities. Such factors include distinct features of vaccine-distribution networks in AI/AN communities, innovative approaches to encouraging vaccination, and culturally attuned messaging strategies for confronting vaccine hesitancy. Communities have created ecosystems to support the Covid-19 response, which expand beyond tribal governments and health systems to include nonprofit and community-based organizations that provide direct services and disseminate health information. It’s also possible that high rates of Covid-19 cases, hospitalizations, and deaths in AI/AN communities prompted an urgent demand for vaccines. Research is needed to better delineate the complex factors associated with high vaccine uptake in AI/AN populations.

Building on IHS and state government vaccine-distribution networks, AI/AN governments, tribal departments, and community organizations led their own vaccination campaigns. Many communities elected to first vaccinate members who are critical to their ways of life, including tribal elders, council members, knowledge keepers, Indigenous-language speakers, and tribal health providers. Vaccinated elders served as role models for others, and the community-directed process garnered trust from tribal members.

A poll of nearly 2000 AI/ANs identified a messaging tactic with strong support: portraying vaccination as the best way to prevent further suffering caused by a pandemic that has brought incommensurate harm to tribal communities. The survey also found that emphasizing the preservation of culture and language, including by protecting elders by means of priority vaccination, increased support for vaccines. Such findings could inform future pandemic-related public health strategies in AI/AN communities.

In some instances, vaccines were available earlier for age-eligible tribal members than for people in nearby non-Native communities. Community venues — including tribal facilities, schools, casinos, and urban Indian centers — were used for drive-through and outdoor community-vaccination events. Some tribes also used monetary incentives to increase vaccination rates; one paid $2,000 to every tribal member who could provide proof of vaccination.

Vaccine rollout sometimes coincided with ceremonial seasons that are central to tribal life (e.g., Lenten and Easter season for the Pascua Yaqui Tribe, summer feast days for Pueblo communities, and the Hanbleceya ceremony for the Crow Creek Sioux Tribe). Where-as some tribes’ ceremonies were canceled because of Covid-19, other tribes conducted sacred events but restricted attendance to members who could show proof of vaccination, thereby creating a powerful incentive for people to get vaccinated.

Even before Covid-19 vaccines became available, AI/AN communities began adapting infection-control and community mitigation strategies to the realities of tribal life. Adhering to CDC guidelines, tribes implemented case investigation and isolation, contact tracing, and quarantine of contacts. Action plans were devised for safely treating people with Covid-19 in AI/AN communities using trained patient-transport teams, household food-delivery teams, and patrols to enforce lockdowns. In some areas, women transitioned from making jewelry to making masks, safety shields, and other personal protective equipment. Protective measures, which were customized in each community, included enforcing stay-at-home orders, sealing borders to tribal lands and barring outsiders from entry, requiring physical distancing, implementing mask mandates, shifting to remote learning for students, and modifying tribal ceremonies.

Social media provided a conduit for tribal members to remain connected, while also per-
mitting the preservation and expression of culture and traditions. Communities offered online storytelling, talking circles, and educational programs and hosted forums for shared practices such as cooking, gardening, drumming, and powwows. Social media sites were also platforms for public health engagement, providing tribal members with updates on their communities’ Covid-19 response.

The ascendance of the delta variant has caused Covid-19 cases to springboard in the United States, especially among young people. Throughout the delta surge, AI/AN communities have continued to lead on vaccination rates, while preemptively reinstating community mitigation strategies, including masking, social distancing, and remote learning.

AI/AN leadership on Covid-19 vaccination brings key lessons into focus. First, ingenuity and resourcefulness among members of AI/AN communities were underestimated. Second, having the autonomy to establish their own policies and priorities was instrumental for AI/AN communities to proactively vaccinate their populations. Third, communities benefited from creating innovative, inclusive approaches to increase vaccination uptake, which included tailoring outreach and messaging strategies to their individual cultures. Fourth, although the IHS, state governments, and the federal government facilitated timely vaccine delivery and distribution to tribal communities, they should enhance their collaborations with tribes to address the underlying inequities that have made AI/ANs especially vulnerable to Covid-19. As the Covid-19 risk landscape continuously transforms, lessons from culturally informed vaccination responses in AI/AN communities could be extended to other populations.

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This article was published on December 18, 2021, at NEJM.org.


DOI: 10.1056/NEJMmp2113296
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Tobacco-free Nicotine — New Name, Same Scheme?
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E-cigarettes that claim to contain “tobacco-free” synthetic nicotine — nicotine that isn’t derived from tobacco — are proliferating. The Family Smoking Prevention and Tobacco Control Act of 2009 gave the Food and Drug Administration (FDA) regulatory authority over the manufacturing, marketing, and distribution of tobacco products, which were defined as any products “made or derived from tobacco.” In 2016, this authority was expanded to include e-cigarettes, which have traditionally contained tobacco-derived nicotine and therefore met the FDA’s definition of a tobacco product. New products that contain synthetic nicotine, however, may not (tech-