Episode 62: The Heart of Diversity & Inclusion.

A Cardiologists' Perspective. Featuring Dr. Sharonne Hayes.

Despite progress, heart disease remains the #1 cause of death in America. Not only does heart disease have a disproportionate impact on different populations, it also has a direct bearing on the severity of COVID-19 infection. Dr. Sharonne Hayes is both a cardiologist and the Director of the Office of Diversity and Inclusion at Mayo Clinic. Here she discusses the importance of understanding cardiovascular disease in the context of health equity. Dr. Hayes also discusses new initiatives at Mayo Clinic to understand and address structural racism in healthcare, and to promote diversity within their workforce. Hosted by Dr. Michelle Leak. Posted on September 2, 2020.

Dr. Leak: Welcome to The Health Disparities Podcast. This podcast is brought to you by Movement is Life. Movement is Life is an organization that advocates for protecting people from the detrimental impact of arthritis by encouraging movement, by encouraging and increasing awareness of health disparities impacting vulnerable populations, particularly women, people of color, and people living in rural areas. Movement is Life also advocates for greater diversity in the healthcare professions. Health equity then is our overall area of interest. I am Michelle Leak. I'm the administrator at Mayo Clinic in Florida, and a member of the Movement is Life Executive Steering Committee. I am your host for today's podcast.

Two facts really highlight a critical connection between heart disease and arthritis and joint pain. First, in 2017, the Center for Disease Control reported that heart disease is the number one cause of death in the US, followed by cancer. And in 2020, it looks like the COVID-19 virus is on track to be the third leading cause of death.

The second important fact in 2019 Mayo Clinic reported that treatment for knee, hip, and back pain is the number one reason that individuals seek health care. We know that joint pain limits mobility and that it results in less physical activity, obesity, increased pressure on our knee joints, and then even more pain. All of which are likely to result in heart disease, Type 2 diabetes, and depression. We also know that movement or more physical activity is the key to breaking this vicious cycle of joint pain and achieving not only joint health but also optimal heart health and mental health.

So, with this in mind, we're going to discuss heart health, health disparities, and the impact of the COVID-19 virus on our most vulnerable populations with renowned cardiologist from Mayo Clinic in Rochester, Dr. Sharonne Hayes. As well as being a busy professor of medicine and a specialist in preventive cardiology, heart disease, and women's health, Dr. Hayes is also the Director of the Mayo Clinic Office of Diversity and Inclusion. Welcome, Dr. Hayes.

Dr. Hayes: Thank you. It's really a pleasure to be here.

Dr. Leak: It's so good to have you. We're just so appreciative that you could join us to discuss these important topics. I'm always interested in stories that inform our career choices and our life's work. Could I ask you to start our conversation today by sharing with us your story in terms of how you decided to become a doctor specializing in cardiology and also what awakened you to this calling to devote a great deal of your energy to health equity?

Dr. Hayes: Well, I will say the part about being a doctor and cardiologist is a little less exciting. So, I'll start there. I was good at math and science. And back in the day, if you were good at math and science, they said, well, you should study medicine. And it seemed to be sort of that course. I didn't waiver and in fact, I went to medical school at Northwestern, which was a six-year integrated program where I got a bachelor's degree and an MD. So, basically, I was accepted into medical school as a high school senior.

I think becoming a cardiologist, I loved everything I did in terms of medicine, some things more than others. I had a hard time because cardiology really was the thing that got me most excited. Back when I was in training for internal medicine, it was when we were making great strides

in both prevention, because statins were relatively new and treatment of hyperlipidemia and risk factors was shown to really be, highly relevant to today's talk, really to be kind of the future. Then the interventions of thrombolysis and stopping heart attacks in its tracks were also all of those early TIMI trials. So, I think it was the excitement of both being able to prevent and do. What were the red flags at the time, only 6% of cardiologists were women back in the eighties? There was a certain amount of why is that, maybe that's a red flag. I think the other was a lot of my view was of these cardiologists running in for STEMI call at all hours of the night and wondering if that would be a lifestyle that I would want. But I have never looked back. Being a cardiologist is great and for all, you women out there who were thinking about medicine, join us.

I think at the same time though I think the diversity and inclusion, the equity and the advocacy for which I have spent a lot of my career, I reflected that the first time I really got out there was in middle school. So, back then it was actually junior high school. First of all, Title IX had just come in. So, Title IX that girls actually had sports had only been around for a few years and there weren't many girls' sports, but they were coming. Ninth grade was part of junior high and it was separate from senior high. The boys in ninth grade got bused to the high school, so they could do varsity sports. The girls were told you have to wait until 10th grade. So, they weren't providing access to girls. So, this is when my friends and I,

said that's a Title IX violation. So we made an appointment and got on the school board agenda, holding our little posters and we went forward and of course, it was a Title IX violation. So, they actually had to change it.

That sat with me because wow. I remember talking to my girlfriends, we were all swimmers and we wanted to be able to swim for the high school team and then got to do it as well. These little voices actually can make a difference and so that's transferred into the little voices of women with heart disease. So, this was back in the late eighties, early nineties, and we were recognizing that there were sex and gender differences, and we needed to move forward and maybe learn better why women were not doing as well with heart disease, whether it was with a heart attack or heart failure, or we're doing differently. So, I've worked a lot with women with heart disease and advocacy, which leads us to today because all of this has to do with health inequities or inequities in some such.

Dr. Leak: Absolutely. Thank you so much for that Dr. Hayes. It's so important for us to use our voice and we can make a difference no matter what our age is. Right? So, thank you for sharing that.

As you have mentioned, one of the things that’s on everybody's mind now is the COVID-19 pandemic and especially how it is disproportionately impacting people of color, women, and the elderly, and hence really

shining a very bright light on health disparities, like we've not seen to date. We know that black and Latino people are three times as likely as white people to become affected by the virus, infected with the virus, and twice as likely to die. We also know that eight out of 10 COVID deaths reported in the US have been among people ages 65 and older. So, Dr. Hayes share with us what you're seeing and understanding about this pandemic and how it impacts so many of us so differently.

Dr. Hayes: Yeah, it's so complicated. I think it's really sometimes has been easy to make shortcuts and say, because of this, this happens or because of this and we have been finding as this rapid gaining of knowledge that sometimes we were kind of wrong. So, one of the things that came out very early that cardiologists were interested in, is that it did appear that there was a higher risk of poor outcomes, like ending up on a ventilator or death in people who had hypertension, underlying heart disease, diabetes, and particularly obesity. And it would've been very easy to say, well, that's the reason that African Americans were having a disproportionate burden and more likely to die. I think that where we really need to peel back the onion a bit on that is that there are other reasons other than just the risk factors that African Americans have. It is because of many other factors; social determinants of health is what we often call them, but one could also say that it is the result of 400 years of structural racism that to a certain extent has contributed to this. Because these same risk factors:

heart disease, hypertension, diabetes are prevalent because of redlining, other economic things, but as well as where people are working.

So, when we talk about what are some of the disparities say for women. So, one of those sex differences is although women are more likely to contract the virus, they tend to be less likely to die. We don't understand that. That's probably something that is a great and rich area of research. Because if there is some gender or sex factor that we could somehow learn about and apply to men. But women and women healthcare workers are more likely to get the virus on average in part because they are more exposed. So, they are more likely to be frontline workers. They are more likely to be healthcare workers. Healthcare workers are 70% of women. So, if you just look at pure numbers, they are more likely.

Similarly, in terms of the poor outcomes for African Americans, it may be because they are exposed to a greater virus load. They're essential workers, they may not have an opportunity to telework. They're more likely to perhaps need to take public transportation where they don't have social distancing. So, you start with the disparities that we already know about, that Movement in Life is so attuned to, and then you take a pandemic, a virus that one, we don't understand very well, but we know affects people who live closely together. And if we think about the economic opportunities and the likelihood that the housing density may be greater, you start

seeing that this combines with the data we already know that African Americans have higher death rates for virtually every condition that we look at.

I think the other thing that if we really want to better understand the coronavirus is, we talked about where people live. So, it may be that the food availability, that healthy food isn't available and then psychosocial stressors and the physical stressors such as unemployment and violence that we've seen in the past few months or environmental like pollution, or lead like Flint, Michigan. So, all these things that were kind of the baseline. If you were having to get bottled water, because your own city water, isn't safe, that's another exposure that you might have.

Dr. Leak: Dr. Hayes you're right on point on all cases there. And I wonder if you could speak just a little bit about, we talk about the social distancing, the hand hygiene, the wearing the mask, but some of those things, although they're critically important, there are risks. For example, by black men of color wearing a mask and walking down the street. So, I think that there are some things of that nature that we have to understand.

Dr. Hayes: So, if you think about particularly this intersection of the deaths by law enforcement of a number of African Americans just going about their lives that really bring home that, do you really want to be somebody who is

already at risk for being pulled over or being questioned by police to add to that risk by wearing a mask, even if that is the safest thing for you.

We still live in an era or an environment of relatively segregated healthcare. So, if you think about the populations at risk, they are on average, more likely to be underinsured or uninsured, and they have less access to primary care, may not even have a primary care physician or practice, and particularly specialty care. There was some early data that came out of the Northeast said that blacks and whites with identical symptoms of COVID-19, the whites were more likely to be referred for testing. So, that was probably an unconscious bias that we haven't even talked about. If we think about some of these external COVID-19 locations many of them are drive up. Think about it. You've already said that you may not have a private car, and then you put a drive up COVID-19 testing in the suburbs, in a shopping mall, that may make it completely inaccessible to the folks who need it. And then, just like we saw in some of the inner-city hospitals in New York, some of the sickest patients were having to go to some of the most under-resourced hospitals.

Dr. Leak: Absolutely. We did learn last month of some work that's going on here in Jacksonville at UF Health Jacksonville, one of the academic safety-net hospitals here, just to that point, in terms of people having no transportation to get to testing sites and how the university took the testing

into their neighborhoods and worked with the local housing authorities to be able to provide that testing right there in the places where people lived and work. So, very important to look at how all of the social determinants of health play out in controlling the pandemic, trying to limit the spread of it, but also we see that these social determinants of health really underpin and exacerbate health disparities, right. One of the things that I heard you say, and I just love this quote because it's so impactful is that it's racism, not race, that's the culprit. And that gets back to the structural racism. So, that really resonates with me and I think it will to our listeners as well.

Dr. Hayes: We can say all we want the statistics about how, for instance, African Americans are more likely to live in poverty or more likely to live in closer proximity and in larger family groups, but there are reasons for that. It is not because African Americans necessarily, or immigrants are choosing to do this. If we think about just economic policy that goes back to the Jim Crow era where you couldn't get a mortgage in certain neighborhoods. And those neighborhoods, if you can't get a home re-improvement mortgage to live in that neighborhood, nobody's going to want to move in. And the houses may not improve as they would in a neighborhood that was. Those were directly based on the racial ethnicity of the folks that lived in those neighborhoods. That then leads to a generational wealth challenge.

We know that most African American families have been in the US for a long time, but if you compare the wealth of a generation for black families is about five to 10 cents on every dollar of a white family. Then there's increasing understanding, although not yet how we will mitigate it, but we know that individuals who have experienced discrimination as young people have higher risk factors for heart disease and other problems. It may be that the effect of stress and discrimination affects our DNA and our overall risk factors. It can't help, but then perhaps make us more vulnerable to COVID-19.

Dr. Leak: So, Dr. Hayes you mentioned research just a little while ago, and I know that this is an important part of your work and specifically understanding how gender, race, and ethnicity can inform research in clinical outcomes. You know that Kaiser News Network recently reported that research shows that people of different races and ethnicities can respond differently to drugs and therapies, much as what you have just said in terms of how different disease states manifest and impact some populations and racial groups differently. So, we know that blacks make up about 13% of the US population, but on average account for only about 5% of participants in clinical trials. And similarly for Hispanics who make up about 18% of the population only account for about 1% of participants in clinical trials. So, I'm wondering Dr. Hayes, what this means in terms of the efficacy of

clinical trials now underway to discover a COVID-19 vaccine. Could you share a little bit of your thoughts in that regard?

Dr. Hayes: So, this is almost like deja vu all over again when I reflect back on trying to get women in cardiovascular clinical trials. So, if we think back in the seventies and eighties, there were a lot of federal dollars that were spent on cardiovascular research, realizing it was the number one killer. And there were actually most of the trials that our tax dollars paid for actually excluded women altogether. So, that was what led to the eighties and nineties realizing those treatments that worked in men, they're not working quite as well or have a different outcomes or different side effects in women. We better study women. So, we started playing catch up.

The other important thing is there was an assumption like there is with race ethnicity that, oh, if we do a study on men, even if we include women, we don't have to analyze the data by sex. It's probably all the same. Well, that has also turned out in some important ways to be a problem and I think that we can assume that there may be because there have been several trials that have shown particularly for heart failure and hypertension, that there may be race-ethnicity, differences in the efficacy and or side effects of the drugs we use as cardiologists.

So, the first step is to take the data that we're collecting now, realizing it's imperfect. We don't have enough women and minorities in our clinical trials for COVID or anything else, but let's make sure we are collecting that data. So, whoever we have in, we can analyze the data by race, ethnicity, and gender. And that's a critical thing to do that is not being done on a regular basis for COVID-19. So, that would be the first call to action is that for every COVID test and every outcome that how they respond to the experimental drugs is that we know who the patients are and that we look. Now, there may be no difference across race, ethnicity, or gender. And we should be able to say that. How powerful, if you are a racial minority who doesn't trust the health system very much anyway, for a good reason and we can talk about that, to be able to say, we analyzed this trial and we found that the benefits or the harms, but the benefits of this particular intervention were excellent for COVID-19. And they were equal for women, men, blacks, and whites because we looked and we included it. That's just going to get we, as treating clinicians, but also for those who are potential recipients of the treatment, more confidence. But if we're really going to, for those studies, that one has to volunteer for, like a vaccine trial. So, right now we've got a lot of brave people across the world who are rolling up their sleeve for these first vaccine trials, which could have some risk, right. You know, there could be side effects, maybe they don't work, but it is possible that there could be some harm. And that could be very scary for somebody who already doesn't trust the healthcare

system. I think we need to help people, one, gain trust in the system and that's by developing relationships in communities before asking them to roll up their arm.

Dr. Leak: Yeah.

Dr. Hayes: If you first ask, "Hey, we want to experiment on you." I can tell you that there will be a huge lack of trust and probably a big no. But if we have been in that community, whether it's an African American or an immigrant community, your healthcare organization working with them, understanding their needs, having them guide what are the most important research needs for your population. You know, is it diabetes? Is it heart disease? Is it prostate cancer? What is the most important thing and then working and developing those relationships? When it's time to implement a vaccine trial, that group is your first responders, because they're the ones you can already have a conversation. That doesn't mean they'll automatically roll up their sleeve, but it does mean that you can have the conversation that comes from a place of trust.

Dr. Leak: So, as you have said, so beautifully attracting a more diverse population to participate in research requires investigators to be more flexible, more innovative, and importantly, to be representative of the populations they wish to reach and serve. So with this in mind, I think about diversity in the

healthcare professions and particularly among physicians and researchers. Right? That's just so critical. So, when it comes to diversity and inclusion, in the context of developing careers for women and minorities in healthcare, how important Dr. Hayes is mentorship, and what advice and guidance would you give in that regard?

Dr. Hayes: You know mentorship in the sciences, medical, and otherwise is longstanding, but we also know it's not just the mentor who helps you do a research project, it is that kitchen cabinet of mentors that helps you navigate a career, navigate a particular problem, or is just like you, and you have shared experiences. What we know is that women and minorities in healthcare, and particularly as physicians and scientists are less likely to have any mentor. They are certainly less likely to have mentors who are like them. And they are also less likely to have the informal mentorship that often happens in the coffee room, or because those happen much more comfortably, for the most part, over exclusion, but it is often an overlooking of the needs of those individuals. So, one of the ways to solve that is to make sure that there are actually formal mentoring programs. If you know, there's a gap in informal mentoring, making sure that you formalize that so there is a team of mentors. That is one thing that for instance, our cardiology group has really done in the past few years is every new staff member has a mentoring team. One's for leadership and one's for their science and one's for and there's

accountability for the mentors and the mentees. I think the other thing is if every woman cardiologist, because we're still a minority, wanted a senior woman cardiologist as their mentor, there's not enough of us. So that leads to the fact that we not only need to train white men to mentor black and brown men and women, and make sure that they're comfortable and that they're needed. Because I've talked to some of my male colleagues and they feel like they're not equipped and that they're not wanted. When I talked to my female successful cardiologist across the nation, nearly all of them say, "There was that one guy and he believed in me, and he's why I am where I am." I think telling those stories of both mentorship and sponsorship. So, mentorship is that active helping people along with their career and advising, whereas sponsorship is talking about that person when they are not in the room and promoting them. Those two things will help a lot in the success of that small pool, particularly of minority clinicians that we have today.

Dr. Leak: Absolutely. So, Dr. Hayes, just to follow up on that a bit. So, how do we make people who do not raise their hand and say, I want to be a mentor to someone who doesn't look like me, doesn't have the same background experiences that I do, how do we engage them and just being open to the opportunity to be a mentor, and then how do we help them to become an effective mentor?

Dr. Hayes: I think that having it formalized a bit, so maybe there's a matching and some support and some feedback. So, allowing that mentor, perhaps to meet with another mentor and maybe a mentor themselves. I'm a big fan of cross-cultural mentoring. And when I say cross-cultural mentoring, that might be generational, that might be race-ethnicity. It might be truly cultural, as you know, a native-born or a very junior person, because I have learned a lot from some of my mentees. Because their life experience is very different and it has allowed me to be a better mentor to somebody else who might be like them and actually a better leader. So, if you frame it like that, where it isn't a mentor, who's this all-knowing person who's going to help you through your career into what do I have that I might be able to bring to the table that can make this a really great collaboration and a win-win. Not every mentorship relationship will be that, but I have had several in my career, whereas I have been extensively the senior person, but have gotten as much or more out of it as the more junior person that I was supposedly mentoring.

Dr. Leak: Yeah. Also, and I love what you said about telling the stories and sharing the experiences of just one person sharing the impact that it had on them to have a mentor. The storytelling is so critical.

Dr. Hayes, you've talked a lot about some of the research that you've been involved in. We've talked about some of the mentorship activities at

Mayo. I'd like to just segue a little bit and talk further about some of the issues at Mayo Clinic that have promoted health equity. So, Dr. Hayes, you have spoken about some of the initiatives that Mayo, in terms of the research that you have been involved in throughout your career in terms of some of the mentorship initiatives that you have led at Mayo and others has participated and helped to advance. I'm wondering if we could talk a little bit further now about some of the initiatives at Mayo to promote health equity prior to COVID and certainly now during the COVID pandemic.

Dr. Hayes: So with that opportunity, I think that you know as I've shared a lot of my early efforts was trying to get more women in cardiovascular research because they were and are underrepresented in those studies. I would often say, if you think we don't know enough about women with heart disease, we know even less about African American and Hispanic women and their experience of heart disease. We know that African American women have increased risk and actually Hispanic women appear to have a lower risk. So, learning about why they have lower risk of dying could be helpful all around. Both to help the higher-risk individuals, but perhaps inform risk lowering things that we could learn from certain populations.

Early collaboration that came through a heart patient and The Links Incorporated, which is a national non-profit advocacy and service organization for African American women, which I know you're familiar

with but they have a health and human services facet, which seemed very aligned to the work that we were looking to do for women, obviously, heart disease being the number one killer of African American women. So, I partnered with a colleague at Emory as well as The National Links Incorporated and some colleagues at Mayo to initially put on a health fair on the South Side of Chicago and really learn about the hunger for women and particularly African American women to improve the health of their communities and themselves, but saying, you know what, I've never been asked to be part of the research. So, I have some trust issues, but, you know, nobody's even asked, so I could say no. So, we did a survey at a national meeting of The Links Incorporated, and that survey showed that yes, there were some trust and some knowledge issues that needed to be overcome, but a lot of it was that we needed to help people like me, who may not be asking, you know, their clinicians, “Hey, we're doing a hypertension prevention trial and we need to make sure that you are invited.” Instead of perhaps assuming that she wouldn't or would have barriers. That led to us being able to successfully compete for an NIH grant to further study this with some Links Chapters in the upper Midwest, which allowed them to develop an educational intervention for black women in the community to better understand their baseline knowledge about research and research participation, and then inform them about why it's important and what are the pros and cons, and then change their attitudes and willingness to sign up for research.

Dr. Leak: Absolutely, that's important work and a reminder of the value in partnerships. I'm thinking about some of the initial work that Movement is Life did in South Side of Chicago in terms of our Operation Change. So, I think that there might be some opportunities to sort of reach out and to make some new connections with the links to Movement is Life and Mayo. We will have to see if we can make that happen.

I understand this as well that you referenced earlier when we were talking about community and engagement in partnership with the community in terms of recruitment for research trials, and I think one of the things that you said that resonated with me, reminded me of that quote from Saint Francis of Assisi, "*Seek first to understand, and then to be understood*." I think that is the essence of the Rochester Healthy Community Partnership. So if you could share a little bit more about that. That would be great.

Dr. Hayes: So, I'm not directly involved, but I'm very proud of the work that my colleagues are doing and have been participating a bit in COVID-19. So, the Rochester Healthy Community Project has been going strong for over a decade and aimed at immigrant communities to help them access healthcare appropriately to deliver health care and health messages in a culturally appropriate way. My colleagues who've been doing that work

have developed these long-standing relationships, not just with individuals, but with community organizations that service those. There's an organization that actually is a resource center for new immigrants and so we worked through them because that's a trusted partner with the community. So, we work with trusted partners and with trusted organizations.

When COVID-19 started hitting as in many and still going on, but there was some very potentially deadly misinformation that was going out. There were messages that Somalis couldn't get COVID-19 they were immune. So things like that, that if you are going to think that you're okay, and then you believe that you're going to continue to congregate and otherwise. So, that group worked through Rochester Healthy Community Project was able to mobilize literally within days educational programs, videos, print materials, and other things in the appropriate language given by trusted individuals to help people understand the actual facts and to meet the needs of those communities for testing and everything.

Then my cardiology colleague, Dr. LaPrincess Brewer has been working for years on developing relationships in African American faith communities in Rochester and Minneapolis/St. Paul. So she has developed these relationships largely to advance cardiovascular health, looking at prevention and lifestyle, and has been working with these

communities and building those trusting relationships. So, when COVID came it was very quick to be able to identify needs. What are the gaps? Is it hand sanitizer? Is it a church disaster relief plan? How are you going to do this and being able to mobilize? There was a clinic up in the Twin Cities that many of the congregation members and their community were going to for COVID-19 testing. There weren't enough supplies, and the results were coming back in 10 to 12 days, which means that they were going to work and infecting other people. We were able to work very quickly. So, those tests were brought down to Mayo to give a more rapid turnaround and had we not had those relationships, it would not have happened.

Dr. Leak: Exactly. And I think we took that same approach and model and from Rochester experience to Jacksonville, Florida, where we have a couple of our physicians, particularly African American physicians who know the community very well and organized a series over the first few months of the COVID epidemic, listening sessions with community champions, community navigators that could be sort of like the bridge between AL and the community to get information, to help dispel myths that were out there in the community about the virus and about participating in research and able to provide some educational materials to take back to the community. Similarly, we have recently just started here in Jacksonville, Florida, that Mayo partnering with initially 11 churches, African American churches, Hispanic churches to do testing on-site at the church. And again, that

rapid turnaround in test results is so critical and important. So, it's nice to see that we can take the learning from one community, from a male at one side, and infuse it with a male from the community on another side. So, thank you for sharing that work as an example with us. Dr. Hayes, one other initiative that I like to just hear a little bit more about is the recent announcement in terms of the financial commitment that Mayo Clinic has made.

Dr. Hayes: You know, after the deaths of Breonna Taylor and George Floyd, literally an hour and fifteen minutes up the road from Rochester, Minnesota, and affecting so many of the nation and internationally really discerning what more should and can Mayo do in terms of addressing racism and health equity, recently announced and it comes from leadership on our board a 10-year commitment of a hundred million dollars with the goal of eliminating racism at Mayo Clinic. You can be a cynic and say, we'd never achieve that and that may be true, but if you set that lofty goal, at least you know our top leaders are really committed and are having the kinds of conversations that are so important to have and looking at where Mayo, maybe hasn't been at its best, whether as an employer or in health equity. This was just announced within the past couple of weeks. We're currently on a discernment and learning opportunities. So, we're really looking for our staff to go all in. In fact, we've got it. It's called Everybody In, with opportunities to learn, to commit personally. So, in addition to the big

organizational commitment, what we're really doing is asking our staff and particularly our staff who are not minorities and maybe have not experienced racism to become anti-racist to understand what racism is, to understand its impact on our people and our patients and our nation and to step up.

So, we're at the very beginning of this journey. I think that it has started conversations within our walls that weren't being had before. I think there are people who previously have felt like, why should I share my experience because it won't make a difference anyway. People are sharing their experiences and being heard. So, I'm optimistic. I am not a Pollyanna. This a 400-year-old national devastating problem that will not go away overnight, but a commitment like that is not to be taken lightly.

Dr. Leak: Absolutely. Thank you for sharing that with us, Dr. Hayes. We'll look forward to hearing what are those lessons learned? I have participated in some of the earlier listening sessions here and what really good steps stood out in my mind is the experiences that our staff across the board have outside of work and that's part of their experience, their daily activities of living if you will. And then they have to set that all aside when they come into the work environment and are expected to perform on an equal footing and the same as our non-black or non-Hispanic colleagues. It truly is an additional burden. And I think you talked about it earlier in

terms of the impact of racism on our health, on our mental wellbeing, on our DNA, if you will. So, I think that this is a tremendous opportunity of learning and understanding and being a force for change.

So, as we wrap up here, Dr. Hayes, I just want to end you mentioned it earlier in terms of a call to action. Each of us we know, can make a difference and make a contribution, whether we're acting individually or leading within our respective organizations to achieve health equity, to speak out against social injustice and racism. So, what might you suggest, we suggest a call to action for physicians, researchers, and healthcare organizations?

Dr. Hayes: I'll start with the individual. I sort of started this by talking about my little middle school activism. I think particularly, and I've heard many physicians feel that they don't have a voice, or they don't have power. They say, why should I tell a patient to stop smoking because they keep coming back and keep starting smoking again. When in fact the most important marker of somebody quitting smoking is actually a physician telling them to do it. So, I think particularly physicians finding their voice and their power and realizing even that they do make a difference. And that is being prepared to be not just a good bystander, but an upstander. So, looking at learning how to be an anti-racist or to address micro aggressions in the workplace, because this is not, you don't have to go out of your workplace. You can

stay in your office and be able to help other people when you witness, whether it's racism or sexual harassment to be able to call it out and help your colleagues, both the victims, as well as those who may have been the perpetrator to perhaps change their behavior.

I would just say, start by what can I do today to learn about something, to understand what a microaggression is, for instance, to better understand the experience of my black colleagues or my black patients that will help me with empathy. So, I'll start with that is something that everyone can do, and they can do it today. I think the things that you can also consider doing is cross-cultural mentoring and whether that is a peer to peer mentoring or volunteering. And not being afraid when you're a senior white cardiologist and they give you the junior black cardiologist that you have something to value and your sponsorship could actually be more important to that individual for instance and giving them the inside curriculum of how to be a great doctor that is very unique. Looking outside at what are some of the policies standing up physicians, again, beyond their practice is talking about what bill or local ordinance or reimbursement or voting maps, where can you step in to help advance justice? Again, you do not have to spend a lot of money or a lot of time, and you do have a vote and a voice.

The other thing I think that people underestimate and particularly those in the majority is we all belong to one or more professional societies, right.

You know, I belong to several cardiology societies. Participate if you are a minority in the women's section or the minority section, be the majority person who sits there, lends your voice, learns from your colleagues, and actually then advocates and spreads the message. If there is a National Medical Association, a Black Cardiology's Association, like the Association of Black Cardiologists, become a member. I've been a member for years and I have met people I probably would have only had a passing glance at a national meeting and been able to collaborate and actually mentor black physicians through that organization. So, there are lots of things that we who are in the majority and may think isn't relevant or isn't possible, that really is, and is not a huge amount of effort.

Dr. Leak: Beautifully stated, Dr. Hayes, a lot to bear for anyone that wants to step up, lean in, and make a difference. And these are not insurmountable opportunities. These are things that each of us can do individually and collectively and things that our organization can help to promote, especially in the arena of policy at state and national levels. So, thank you so very much again, for taking the time today to visit with us. You have helped us to really zero in on what are really the issues that we're addressing and to really call it what it is. So often, we sort of sugar coat it and don't say what it is and what everyone knows that it is, but we just don't articulate. So, thank you for being that, that voice that's been very clear and very motivational and aspirational. We look forward to continuing

the conversation in other venues and partnering with you and any opportunity that presents itself. So, thank you so very much again, Dr. Hayes.

Dr. Hayes: Well, thank you, Michelle. And what it is, is racism affecting so much of particularly COVID-19, but also affects cardiovascular outcomes, which of course is dear to me. And thank you for all of your work with Movement is Life because I can tell you one of the biggest barriers for active participation in cardiac rehabilitation is joint pain. It's musculoskeletal. And so, I think that the partnership is just so important.

(End of recording)