Laura Gordon: Thanks, John. Well, I want to say that I know Kim had a lucky job to talk with Steve just now about his report, but I have also a lucky job in being joined by some pretty amazing panelists this morning. We are very fortunate to have them. They are very busy people so so glad that they are willing to spend time with us. I'll introduce our panelists now, and then we will kick off into our discussion.

So first, the Honorable Steve Benjamin is the mayor of Columbia, South Carolina and as you know is instrumental in our Move with the Mayor program. Dr. Clyde Yancy is the Diversity and Inclusion, the Magerstadt Professor of Medicine, and Professor of Medical Social Sciences and Chief of the Division of Cardiology at the Northwestern University's Feinberg School of Medicine. And Dr. Arthur Caplan is the Drs. William F. and Virginia Connolly Mitty Professor of Bioethics and the Founding Head of the Division of Medical Ethics at New York University's Langone Medical Center. So thank you all for joining us this morning.

I'm going to start off, and this is truly a foundational piece of this discussion that we're going to have today. So I'm just going to introduce sort of the situation and the issue and we will start at the beginning. It's been an uphill battle to build public and political support for preventing cardiovascular disease. That comes as a surprise to none of us at this meeting today. And if we can't sell the public and our politicians on the importance of prevention in general, the question is how do we convince them to drill down even further to address the disparities in access to preventive care.

So I want to kick off the discussion by outlining some of that foundational problem, and I wanted to start with Dr. Caplan. The first question is telling us in your opinion have we made the case with the general public, or at minimum with those who fund public health, that disparities in population health are a moral and/or ethical problem. And if not, what's getting in the way?

Dr. Arthur Caplan: We have not, and we have never done it in the history of the country sadly, unfortunately. Many Americans think that access to health care is simply a privilege, something that you get if you can afford it, or it's something that you earn by working. We're one of the few countries in the world that gives access to health care based upon employment. That's how you get your health insurance for many people. And while there are certainly many subprograms for the elderly, there are programs that exist for Native Americans, but the idea morally in this country is you either earn your health care because you deserve it because you work, or you can purchase it and it's something that society doesn't have an obligation to give

to you. I think even in the debates that surrounded the Affordable Care Act pro and con, it was never really sold to Americans that we should expand coverage because morally it's important that people have a right to health care.

In my own view, the way to do this – different countries do it differently. Canada, for example, has extended coverage by saying it's something that citizens owe to one another to protect them. It's kind of community solidarity. Well, that doesn't go so far in the United States. We're more divided. We're fractured by race and class and other variables, religion. So it hasn't sold. Britain came up with a certain kind of coverage because it rewarded people for World War II and enduring The Blitz, basically that simple. Germany sort of went with it on productivity.

My suggestion, and I'm happy to pursue it but we probably won't solve it today, is to say, look, if you want equal opportunity in a market-driven society, you have to give everybody access to basic health care otherwise they can't compete, they can't fulfill their capacities, they can't do what capitalism wants them to do which is try and maximize their self-interest, their contribution because they have a loss of hearing, they have hypertension that's getting the way, they can't be mobile, they can't see, they have lousy dental care, they have cardiovascular risk factors that are going to take them out of the economy.

So for me, we need a moral case. We should proceed with making a right to health care basic because I think it's fundamental to where we're going with cardiovascular health if we don't do it. I don't think we'll get there very fast both with prevention and treatment. And the basis for it, I think is a very core American value, equal opportunity. I think that might wash in this country. But to sum up, we haven't done it. We don't have it. There's no commitment in our society to say even children and all Americans have a basic right to health care. We never pushed that through.

Laura Gordon: And just to follow up, have we come any closer at all with the current pandemic? Has that opened hearts and minds to any degree in your opinion?

Dr. Arthur Caplan: No. Sadly, I don't think so. We have big needs. Obviously, people have different abilities to both access experimental treatments. The president gets access to Walter Reed and a lot of novel, therapeutic approaches. Other people wind up in the hall in a poor hospital trying to get a bed. I don't see enough outrage about that gap in access between say presidents and paralegals or police, the people

who aren't potentates and poobahs. Also, we've gotten almost inured to the idea that there's going to be different levels of access depending on whether you're a prisoner on a Native American Indian reservation, whether you're here illegally, whether you are somehow, or another entitled in different ways. So there's still plenty of political opposition even to the extensions of the Affordable Care Act. I think we're going to have to recalibrate. I'm sorry to report I don't think the pandemic is advancing the moral case right now.

Laura Gordon: Thank you.

Dr. Arthur Caplan: And if that wasn't a grim enough way to start us off, I can expand.

Laura Gordon: I'll fault myself for starting us off with that, but it had to be introduced. Dr. Yancy, I'd love to follow with you. And when we spoke the other day amongst us panelists, you had noted that the sheer magnitude of health disparities, particularly racial disparities, how much that's been thrown into stark relief as a result of COVID-19. You mentioned a certain solidarity that you were feeling among physicians and providers. And so I wonder if you might speak a bit about what you are seeing as well as from the providers/physician point of view what impact that could have.

Dr. Clyde Yancy: Laura, thank you and good morning and good morning to all my co-panelists. And Arthur, you did give us quite the start. I also want to say good morning to John Clymer and to the organizers and the leadership for this 18th Annual Meeting of the National Forum. I am really enthused with your title, "Cardiovascular Health: More Urgent than Ever." And Laura, the things we're talking about right now really press that sense of urgency. There are several points that I want to make in response to the question you just posed.

When one looks at the revelation of the depth and magnitude of health care disparities now clearly revealed by COVID-19, there is a chasm; but we have to understand this in a context of scale. Ordinarily, persons like myself and others in the National Forum that are involved in this kind of group specific research will beat the drum loudly because there's a 30 percent difference in a certain outcome or 40 percent difference in a certain outcome and it aligns according to race or gender or age or ethnicity. This time, this time, Laura, it is a 400 percent difference. Blacks are four times more likely to die from COVID-19 than whites. Four times. That's 400 percent. Think of the magnitude of that arithmetical assessment. So just by orders of scale, this is incredible.

I know that we are thinking carefully about the ethos of our country in times where there is a certain amount of divisiveness, but at our core I think we covet the fact that we are a civil society, and in a civil society we are not prone to allow one group to suffer from anything so disproportionately. So that was the bellwether event. That's the first point I'd like to make.

The second point that I'd like to make is that COVID-19 in particular, especially because it is transmitted by human-to-human contact, COVID-19 has taught us that the absence of health in any one of us affects the health of all of us. So we can't partition parts of the community away from other parts and say that's a problem over there, that's a problem here, that's not on my page. It's on everybody's page. The price that we've paid, the death that I've seen, the suffering that I still see in people that are now dealing with the long-term, lingering consequences of COVID-19 is incalculable.

We have to appreciate that all of this comes at a cost. The dollars and cents no longer get anyone's attention because we hear lots of zeroes all the time. It's the pain and suffering of the human soul. It's the fracturing of the human spirit. It is the essence of what makes us who we are and that's what's been so incredibly threatened. So the first thing I want to share with you is just by scale, this issue has been incredibly important; and by consequence, losing our health universally has been of great consequence.

But I want to give you one more point as my third response. Much of what I've put in writing, much of my research over the last six months has emphasized the argument made so well by many others in this space, that it's less a function of race and more a function of place that's driving what we're seeing now. Because people live in communities that de facto are segregated, it's not the fact that they all live together. It's the fact that that leads to a clustering of their social disadvantages that's been put in print by many others. And that clustering of social disadvantage and the historic underinvestment or even disinvestment in those communities leaves people particularly exposed, particularly vulnerable.

We in medicine, and there are a number of physicians in the room today, we in medicine hold tightly to the oath that we all declared when we receive our degree and it says, first of all, do no harm or *primum non nocere*. That's the Latin derivation. What would happen, Laura, what would happen if the persons who instituted

social policy took an oath that first of all we would do no harm? Would we then have communities that have food deserts? Would we then have communities that have poor access to education? Would we then have communities that have heavily clustered housing? Would we then have communities with high crime rates because there's not another economic option? This is I understand almost an existential question, but we've got to do something different than we've done before.

And can we not extend this concept that we embrace so fervently in medicine, "first, do no harm," beyond medicine and have it touch policy? I think we have seen the harm of errant public policy clearly exposed by COVID-19 and borne disproportionately of a magnitude of something we've not ever seen before in a group of individuals. Thank you for the opportunity to start this conversation.

Laura Gordon: Thank you. Your points are excellent and so relevant. Well, let's bring Dr. Benjamin – sorry, Mayor Benjamin into the conversation. Mayor Benjamin, you bring a deeply community-focused perspective to this discussion. You are a passionate advocate for prevention in public health. So you are seeing this firsthand every day and it's something clearly you care very much about. I'd love if you could just share, sort of building on what we've heard from the other perspectives, what the barriers are that you encountered in seeking public support for prevention and population health and talk a little bit about whether you're seeing any more traction with message in the current pandemic.

Mayor S. Benjamin: Sure. First of all, I appreciate the elevation to Dr. Benjamin. While I do have a JD and I have an honorary doctorate over here that might be representative of my life's work, it was a really long, hard afternoon I took to earn that. So unlike my esteemed panelists who are nothing short of amazing – I could sit here and listen to Dr. Yancy and Dr. Caplan all day long and feel edified and strengthened a public sector leader. The challenges are significant.

And I'm a mayor. So if you're a mayor, you're also required to be a member of the eternal optimist's society as well. You believe in cities. You believe that cities ought to be a platform for human potential, ought to be places where people can live up to their true and full potential. The triple pandemic that we're facing now, both the greatest pandemic since 1918, the greatest economic disruption certainly in an election year since 1932 or 1876 depending on which historian you talk to, and the social unrest around police balance and structured racism since 1968 all wrapped up into three

quarters in 2020 has presented both some existential challenges as Dr. Yancy said, but also, I think some opportunities.

Obviously, we're not all sharing in the pain equally – those of us who have the ability and luxury maybe to join in multiple Zoom calls a day and socially distance and those who live in the bottom quintile, two bottom quintiles of society who occupy jobs that are probably being accelerated out of existence with the future of work in automation and AI do not have the luxury of social distancing and obviously makes them more prone to COVID-19. It still has put us in a position where everyone is, for one moment in time, sharing the pain. And I think it's forcing everyone to pay attention to these gross inequities that exist all across our society. Someone, a speaker I was on a panel with recently, characterized it as America undergoing an x ray this year that is clearly highlighting all the broken bones in American society.

So I will say that the optimist in me has seen as a result of the pandemic a great deal more intergovernmental and intersectoral collaboration than we saw prior to 2020. So that's good. There's a great deal more dialogue happening. There's a great deal more of a focus on these disparities because at least those who are actively thinking about solutions, we realize that there's a public health threat and that until you address the public health threat, you'll never be able to address the economic crises. You'll never be able to address the educational crises that we all want our kids to go back to school. So folks seem to be innovating around solutions in various communities across the country with the mayors that I dialogue with on a regular basis.

I will say that things have been made that much more complicated, I will say, by the politization of the pandemic and the ability to get people not only access to quality care, access to services in neighborhoods, but access to just good information. I mean if you remember early on, I mean still obviously sometimes we appeal from the highest levels of the Republic, but early in the pandemic, the ability to just get solid information that would indeed save their lives and save the lives of so many around them, we were not only getting conflicting information, but we had those in positions of power with a very strong bully pulpit that were pushing out false information. That created some major challenges. I believe we've overcome that as the pandemic has sunk in, but I think we're also now starting to see some people who are a bit fatigued. There's a great deal more work to do before we come out of this. I'm an optimist. I love seeing the partnerships that have emerged, some that did not exist before 2020. But it does require each and every

one of us who have a strong public voice and podium to speak that much louder, that much more aggressively, and that much more frequently than we may have before 2020.

Laura Gordon: Yeah. And your point that you made earlier in your discussion was everyone's feeling the pain and isn't that really what it comes down to? If you're not feeling the pain, you're less likely to act or want to help or be part of a solution. So unfortunately, that's what it has come to; but I guess that's what a pandemic does. All right, well, I think it's important. I think we all came together today looking for solutions. We're not going to solve the problem, if you will, today; but I'm going to come back to Dr. Caplan and his payback for being so pessimistic is he's going to have to be the first one to help us think positively about where can we start to find solutions of what are the steps?

So Dr. Caplan, I mean you're welcome to broaden out on this in your answer, of course, but the initial question I have is when it comes to a foundationally ethical, or unethical in this case, or immoral problem, what are the factors that have to be involved to successfully get people to look very hard at that and address it as such? So is it the messengers? How do you get people to say, "Well, that's immoral and we've got to do something about it"? Is it who is saying it? Is it what the message is? Is it how much money you have to throw at the problem? Is it all of the above? Help us start that conversation of where you begin to move forward against something like that or towards something.

Dr. Arthur Caplan: Well, I do think that you can draw upon the current plague to point out to people that they are – and I think it was Dr. Yancy who said this – they're sort of in the same boat. You can't just say, well, I'm in the burbs and I'm not bothered by urban health care problems or public health problems because with something like this, highly infectious, everybody is reliant on one another. So that means we have to think about access to health care as something that is a community concern. It isn't just taking care of your own, taking care of your family, taking care of your local community first. In an epidemic with infectious disease, what goes on in one part of the world impacts what goes on here. And so we have to rethink this notion that we can kind of stay, the upper class, the rich can stay in their bunkers and achieve good health indifferent to what happens elsewhere.

I think it's also been pointed out that the costs – I think it was in the opening lecture – are borne by us all of not having access to health care that controls preventatively. Things like cardiovascular

disease, cheaper to do it through getting people into basic health care and having their conditions like hypertension managed well 'cause it saves money in the pocketbook. Third, by creating risk factors that are preventable, we just increase the death rate. And so if we want to prevent bad events happening from say our grandma or our veterans or people living in the inner city or the people that make our food or clean our dishes or clean our houses, don't want to kill them, then we've got to start acting, again, in ways that show interdependency.

So I am going to sum this up by saying part of the message has to be we're interdependent, we're interconnected. I hate to put it this way, but none of us is an island. I know there are people digging bunkers and trying to run away from social turmoil, but that isn't a public health policy. That isn't even a health policy. In health policy, it's the interconnectedness of us that matters. And yeah, I do think the messaging counts. Look, we have a gigantic health care system that is completely oriented towards rescue and therapy. It is not oriented toward prevention. It just isn't. Have to change that. We're great if you have a heart attack. We can probably get you in somewhere and get you pretty good care almost anywhere in the country.

Somebody said what's the access to prevention programs, monitoring diabetes, monitoring hypertension, trying to work with people – we're not very good. I think that's been noted as something where we have to argue in mainstream medicine to shift our focus. We have to spend more money on social science and communication, so we know better how to achieve behavior change which we're not great at. By the way, notice that we're not even great at trying to get people to support vaccines. They distrust them, and even if we got a vaccine, I'm not ready to say that a huge number of people would take that vaccine. We don't really understand how to change that behavior. So that's just a concrete illustration of what's missing in our health care research.

Then I think it does matter who the leaders are. Without going completely political, messages that pull us together and that say we have to work together to protect one another, I think will help get us where we need to be. Messages that divide us or tend to point to racial, ethnic, religious, economic division, I don't think they're going to get us where we need to go.

Laura Gordon: Thank you. You're right. Yeah, I mean talk about behavioral, the vaccine issue, we can't even get people to wear masks, much less get a shot. So that tells where we are right now. Well, thank you

for setting up the next question which is for Dr. Yancy which is focusing in on prevention. You know, Dr. Yancy, as Dr. Caplan just said and as we all know it, doctors treat. Treatment is well within everybody's in that, you know, every provider's bailiwick. Prevention is harder to find time for. It's harder to get to the prevention part when you're focused first on getting a patient well. So but Dr. Yancy, when we were talking the other day, you mentioned this sort of feeling of solidarity, that sort of you've been feeling even more so. I guess I wonder, does the pandemic in your experience or among your colleagues, are you looking at prevention even harder now or trying to find those opportunities given the fact that people with comorbidities and have preventive conditions are now more at risk of illness and dying from COVID? How is that affecting your prevention efforts?

Dr. Clyde Yancy: So Laura, you really have touched on an incredibly important point and it would probably subsume the rest of the time if we talked about the foibles in our system that don't allow us to actively practice preventive medicine. But I'm going to leverage something that Mayor Benjamin said because for someone who has spent a career saving lives and dealing with advanced heart disease and trying to rescue people at the very edge of life, we have really become sobered by the importance of preventing disease and we try to convey those messages.

What I was conveying to you earlier in our previous conversations is that what has been unique at this moment in time has been the shocking reality that's been a comeuppance for care providers, nurses, respiratory therapists, and especially physicians. What we have seen is indescribable. So there's a camaraderie that I've not seen before. There's a unity that I've not seen before. There is an esprit de corps that says no matter what, we can't let this happen again. I mean we're seeing people suffer – and I want to emphasize that – that suffer right in front of us.

But let me also pivot from something that Arthur said and use the example that you set up, Laura. A lot of what is lacking is the right messaging, and that is part of our dilemma with getting people to just do something simple like wear masks. I'm going to raise my wrist up and you'll see that I have a pink wristband on. This is October. This is breast cancer awareness. Breast cancer has exacted a horrible toll on my personal family, but that's not the issue today. But there was something about this messaging, something about this messaging that got everybody to line up and get onboard and, to use the vernacular, do the right thing.

So to distill this into action items because we're talking about being solution focused, the first thing we need is more science. I am convinced the truth will always prevail no matter what, and we need science. Science that's credible. Science that's trustworthy. Science that's interpretable, and science that can be communicated. That's my job. People like me, that's what we do. But we need more science, and we are actively involved in curating that science because we need more information so that our decisions are not based on heuristics or empiricism, that is thinking about what might work but rather are based on what will work.

But even beyond that, I think it's very, very important and we think about solutions, is that we have to address the leadership void and I'm not talking about politics. I'm talking about in the science and public health community. We have not had that voice, that entity, that organization. Whatever you want to describe, we've not had that central theme that has stood up, locked arm to arm and say, this is what we need to do. And I don't know why we haven't been able to corral that kind of messaging amongst all the people that have a commitment to this. But there has been a dearth of leadership. I think we have to be plain spoken. Because if we don't want to replicate what we've seen so far, we need to address this dearth of leadership in the science and medical community with a trusted voice that the citizens and the communities will respect.

That's the last part of my response to you in terms of solutions. We have to restore trust. We have to make it so that there is no suspicion about what's being said. We have to make it so that someone says just like there is complete trust in pink, we need to find a way to get complete trust in the simple messages so they're not contentious, they're actionable, and they're fully executed. So my response to the question you've raised about what I have seen and how can we do things differently, what are the solutions, I think we need more science. Many of us are actively working day and night to get more science. I think we need to identify our leadership force. I mean I don't want to impugn anybody or any organization or any entity, but we need a leadership force. Leadership for something like this about owning it. We've seen very, very few entities that are willing to own this and move forward with it.

And then finally, I think we need to be very thoughtful about how we communicate and how do we convey trust in the messages that we're communicating. If we can do that, then we have a fighting chance next time around. But you know what? It all starts with science. I've just been in medicine too long. We have to have

evidence. When we have science that's verifiable, we can really move from there. And that is the one thing that is done better in the United States than any other country on the planet. We do science exquisitely well by orders of magnitude better. Why are we not using our best resource to address this problem? Let's lead with science. I know you expect me to say that Laura, but I'm saying it anyway.

Laura Gordon: Shocked. But you know, you raise a great point where clearly there's a trust deficit nationally and it's never been deeper. But, you know, what I have continually seen is that patients particularly continue to trust their providers, their personal doctors. And so it seems to me that there could be some harnessing of that esprit de corps that you mentioned to get that –

Dr. Clyde Yancy: Laura, you're exactly right. No, you're exactly right. I mean the heavy lifting right now, it's hand-to-hand combat. I hate to use a military analogy, but it's hand-to-hand combat. It's when a person comes in. It's the family member that talks about another friend or family member with COVID-19. What can we do to prevent it? That is a teachable moment. When that happens in the office, I can assure those are takeaway messages and people embrace those. So you're exactly right. That same spirit of unity that I'm witnessing every day, even months into it it's still there, the way that's enacted is that hand-to-hand, face-to-face as much as we can messaging that says, okay, whatever else you're hearing, please do this. This will make a difference.

Laura Gordon: Mm-hmm. Because even a person who may be skeptical of science in the broad way that we're seeing it is still going to trust when they're in an exam room, they're going to trust what they're hearing from their doctor. That's my thought. That's my assumption.

Dr. Clyde Yancy: Thanks for the shoutout.

Laura Gordon: Thank you. And so, Mayor Benjamin, where are you seeing the sparks? So in your community, you have embraced a prevention message, a public health message. What's worked in your experience? Where have you seen that lightbulb go on? What would you do more of?

Mayor S. Benjamin: Well, I think just tying in the comments of Dr. Caplan and Dr. Yancy, the common nonstop, frank, but uplifting messaging that talks about the power of us when we work together to solve a problem, how this particular challenge of COVID-19 is something that we can only solve together and speaking in terms that bring

people together has been important. It's been a consistent theme whether it be around public health or the economy or what have you. So I believe that messaging from public sector leaders is important. I also believe that I couldn't agree more with Dr. Yancy that public health data and science has to drive this discussion. That's so important.

Then you have to take that data, you have to humanize it in a way so that it relates to people because sometimes our eyes get glassy when we see numbers. Some people will suggest they can't understand them. But when you see Dr. Yancy talk about breast cancer awareness in his family, I host a radio show and I had our own Mark McEwen come on and share his experiences. Again, the data is consistent but when we humanize that in a way, particularly with a trusted source like Mark, it communicates it to people in a very different way. Gave me the opportunity, as a public sector leader, to be transparent about my family's history with heart disease and how I take a drug for hypertension and how there's no shame or cloud around that.

So I do believe that science, public health data, and then finding ways as much as possible, again edifying ways to humanize that data and share it with the public in a way that's very transparent helps. I got a dozen phone calls from friends and family and a few e-mails from folks when I sat down in front of city hall a few weeks ago and got my flu shot publicly. People loved teasing me about the fact that I was sitting there, and I may have winced a bit or what have you. But again, it demystifies it. The numbers are the numbers.

Again, it humanizes it in a way so that the same calls I got when we first started with the mayor, with the National Forum, gosh, so many years ago when John first reached out to us and the team with the idea. We were like, okay, this could be pretty cool. Then obviously we watched the crowds grow and grow and grow and the news wanted to cover it and we started seeing citizens doing more walking as you want to build that more walkable, bikeable, interconnected community where people are using the public realm in the ways that you're supposed to in these living, breathing cities. It all adds up, but it starts with a good strong public health driven, data driven, scientific base that we then have to communicate in ways that are humanized for folks to really take them in and internalize them. I think they all work. I believe they're additive. You just got to sort of keep at it and never throw your hands up. Obviously, working with folks like you makes us in the public sector that much stronger every single day.

Laura Gordon: Yeah, that's a great one-two punch. Start with the facts, start with the data, and then help people understand them in ways that they can embrace and make real for themselves. So I think that's a great formula. I have one question for each of the panelists, but I did want to just emphasize that if anyone has any questions, I'm happy to raise those with our panel. We do have some time. So you hit the Q&A button your Zoom screen and you can submit that. So if anyone has any questions, they'd like me to raise live, please submit those.

But in the meantime, you know, at the risk of using a rather ubiquitous term which is audacious. You know, people talk about what's the audacious idea? What's the audacious thing we can do? But I'm going to raise it anyway. So and I will raise it to any of the panelists who would like to respond. If resources were not an issue, if politics were not an issue, what's the big thing we could do? What is something, you know, the dream thing that we could do to get people to focus on not just prevention but the inequities even in access to prevention, the inequities in getting messages to people and to allowing them to act on those messages? Any dream you want out there just in case there's a big foundation listening right now that wants to fund it and take it and run with it? Dr. Yancy, you mentioned leadership. We need leadership. What could we do to lead the charge?

Dr. Clyde Yancy: So let me start because I really love the way you set this up. There is an incredibly important report generated by McKinsey & Company in April of this year, 2020, that makes a strident argument that the solution, as much as I embrace science, as much as Dr. Caplan and Dr. Smith really embraces – Sydney – really embraces prevention and I do as well, the answer is economic. That's the answer. I mean that's the fix. We should think about reinvesting in the communities that have suffered from this historic disinvestment over decades but restore the sustenance of life in these communities.

One of the inviolate metrics that we see in public health and in cardiovascular medicine all the time – the two fields that I follow – is that cardiovascular health, public health exactly tracks with economic security. Once you lose economic security, your public health falters, your cardiovascular health dwindles. We take the approaches of doing the vaccines and doing the masking and looking for the size and trying to find the silver bullet to treat this.

One actual tool that would work the most is an economic

investment in the communities. And for those people that say, well, that's going to be too expensive, that's going to be too hard. No, no, no. The only thing that prevents that from happening is will. It's the only thing that prevents that. Having sufficient people with vision to say we need a better fix than we've explored. Let's go into these communities. Let's restore their local economy. Let's provide the jobs. Let's let that generate the new housing. Let's let that generate the new markets. Let's let that bring the commerce that will lead towards healthier lifestyles.

But I think that the way we've been going about this, as much as I embrace science, has not been sufficient. It's not been wrong. It's not been sufficient. I think the next strategy, the audacious goal – and I don't step away from that term because I think we need something audacious if we don't want to go backwards – it's economic investment. And all it takes is will. I refuse to accept the argument that it's too expensive. It's not expensive. It may be unpalatable for some, but it is executable, and it will have a payoff that would be remarkable. The economic return on those investments and a benefit in health. I'm not talking panacea, a blue sky. I'm talking about a realistic strategy, a solution that can lead to a better life for communities that have no idea what that means. Economic investment, that's the audacious goal.

Laura Gordon: We've certainly seen a willingness in this country to spend lots and lots of money on the downstream consequences, you know on health care treatment and the hospitalizations and the nursing home care and all the things that happen when we don't prevent so.

Dr. Clyde Yancy: Think about how many iterations, a trillion, let me say that again, trillion dollar packages that we want to enact and the awareness of how much debt we're willing to hold to navigate these trillion dollar packages. What would happen if there was a trillion dollar stimulus in these marginalized communities, in the underserved communities? Would that not give us a long-term solution? All it takes is will. All it takes is will.

Laura Gordon: I love it. Dr. Caplan, do you have a –

Dr. Arthur Caplan: Yeah, just a couple of points. One is, you know, there was a lot of talk early in the Trump administration, we talked about at different times about infrastructure investment. That may seem a distance away from what Clyde was talking about, but I think for economic investment, if you build better infrastructure, roads, if you have better access to air travel, if you try to make sure that the country is interconnected and efficient through bridges and so forth, it doesn't

sound like it has much to do with health care, but I believe it does.

I think it actually gives people better access, better ability to get to what they need to make sure that if we actually included infrastructure things like power supply, air conditioning. I mean how many people are dying from cardiac problems due to heat outbreaks? What about trying to do something about our massive fires with all their smoke that clearly imperil cardiovascular health in terms of better – sound like the president – forest management but also the ability to get up there and fight the fires and systematically improve our or get rid of our alliance on fossil fuels. I don't think – anyway, I would like to see a politician seem willing to do it. So let's call them on it and say, whatever happened to trying to build up our infrastructure because I think aside from housing and food, those would be good things to try and improve health.

The other is I'm not happy with the National Institutes of Health. National Institutes of Health does great things. It does research across the board on finding cures. But we don't have a National Institute of Public Health or Preventive Health or something that would be doing research on behavior change, behavior modification. I said it before. I'll say it again. I still think relatively speaking, we don't understand much about how to get people to change their behavior. I mean I'm not complete in the land of ignorance, but we need to do better. We need to know how to get people to trust the system. We need to message more effectively.

I find myself thinking – I'll use this metaphor. If we're talking about diet and the battle is, you know, McDonald's advertising versus the City of Baltimore Public Health advertising, having a poster with an apple on it is not quite going to balance out where the fast food guys are. So that's the kind of gap I mean.

Laura Gordon: That's a great point. I drove by a bus stop ad the other day, and it was a public health ad, and it was like a rabbit with a carrot. I thought, oh boy, we've got a long way to go. Mayor Benjamin, do you have anything you would like to add the audacious discussion?

Mayor S. Benjamin: Certainly. I'm inspired by both the answers. Dr. Caplan really got me. By training I am a public finance attorney. I am the chairman of Municipal Bonds for America, one of the foremost advocates of investing in the infrastructure. Obviously as we deal with the challenges of a pandemic that have affected the economy, sound infrastructure investment will be a driver in helping us recover from our economic challenges. Before the beginning of the

pandemic, the American Society of Civil Engineers has consistently given us a D or D+, D+ in a good year, on the state of America's infrastructure primarily invested by state and local governments. A national infrastructure plan would indeed drive the types of capital and job opportunities into so many areas across our country when we're talking about potentially losing nearly $4 trillion in GDP because the lack of investment. So there's some real opportunities there. Every billion dollars you invest creates 15,000 well-paying jobs in the community. So there's real opportunities there.

My thought would be, as you choose to think audaciously and bold, to find some place where there's some synchronicity amongst the leadership. So I would normally say Columbia, South Carolina because I promote my city; but there's not that level of synchronicity. There's actually a fairly decent delta between me and the governor and our approaches to public health but if you have some places. Cities and metropolitan economies over the last several decades across the world are growing, and we're going to see what impact the pandemic and its effect on density will have on that. But we're watching now and cities and metro areas account for 85 percent of America's population, 89 percent of the jobs, 92 percent of America's GDP created in these places.

So if you find one community – and all the places I'm thinking of right now, there's still a pretty decent delta between the governors and the local leaders, but you have – say cities all across this country. Those metro areas in Atlanta has a half a trillion dollar GDP. The ability if there's some synchronicity among leadership to pilot some ideas there that are incredibly comprehensive, that are public, private, philanthropically funded. if there's a significant amount of CARES Act funding there, I mean there are ways in which you can successfully, audaciously attack this problem in one community and show the success and then be able to scale up all across the country.

It does require significant public sector leadership, particularly on the federal level. Dr. Yancy was 100 percent on point. I mean a year ago this time there were several things that America was told we couldn't afford, whether it was in health care or Dr. Caplan who was in infrastructure. And yes, this spring we cranked out not only trillion dollar packages but multi-trillion dollar packages in succession. I mean so if there's a will, the resources are there. If there's a will, it just requires us to constantly push for that leadership, again in the intersectoral way, intergovernmental way and then to demand it of that leadership from our public sector

leaders. Hold people accountable when in fact they don't step up to meet the moment.

Laura Gordon: That's great. Thank you for adding that. Well, before we wrap, are there any other comments our panelists would like to make? I don't have questions from the audience so that leaves you. Any final words? Anything we haven't touched on that you want to make sure we do before I hand it back to John?

Dr. Clyde Yancy: I just want to express gratitude for the opportunity to come together with people that are thinking very differently about the same problem. I don't know that we landed on the solution, but I think when you get input from the public sector, from government, and you get input from public health experts deeply committed to this, when you get input from bedside office physicians, people that do clinical research like me, when we get input from CEOs like you, Laura, I think we ultimately come to some center spot that says we can all agree that at least these things represent what we should do.

So I think the organizers did a brilliant job of bringing thought diversity to this equation. I don't think we've had enough thought diversity on this particular challenge and, boy, is there a crying need to curate as many thoughts and come up with a different direction. If we leave with nothing else in mind, it should be this. We have to do things differently going forward. It's difficult to end with this comment, but we think see the resurgence of COVID-19 coincident with the new flu season and expecting an even greater burden coming forward. We have to do things differently. Period. Thanks for the opportunity to speak.

Laura Gordon: I did get one question just now that comes in from Dr. Dodani, a cardiologist and epidemiologist in the audience. The question is to Dr. Yancy. While many issues pertain to state and government, what can academia and health care providers due to curtail the cardiovascular disease and its consequent to COVID and I would imagine connected to COVID?

Dr. Clyde Yancy: You know, this is a great question. I'm not surprised that a peer cardiologist would be thinking the same way that we think because we in cardiovascular medicine in particular take pride being evidence-based. And so what we need to do is to be certain that as many opportunities as we can exercise, we invite enrollment in a number of pivotal ongoing clinical trials that will give us that evidence-based information that we need. I know this to be true because I'm working with the NIH and we are leading four very

unique clinical trials as we speak attempting to answer these questions. There are any number of registries that are allowing us to get observational data. I know this to be true. The American Heart Association is sponsoring one of the most important registries. So as cardiologists, we need to participate in the data gathering.

And then as clinicians, we need to understand are we able to check our biases at the door? This is profoundly important because we have to make critical decisions about how we treat patients. If a patient is not like us, and this impacts me as a provider, are we able to pause, check our biases at the door, and treat the patient for precisely the problem that's there without any modifiers based on age or ethnicity or gender or life circumstances? That's a challenge because most of those decisions are subconscious and it only changes when we exercise awareness that we're driven by subconscious behaviors.

So that's my message to my peer cardiologists. Participate in the generation of science, please. Think about checking your biases at the door, me included. And then if you have the authority, think about how do we diversify our workforce. That whole comment I made earlier about diversity of thought, we need that in the clinic, in the ICU. We need that diversity of thought there too. So three answers to my peer. Thank you.

Laura Gordon: Dr. Caplan or Mayor Benjamin, any final comments that you would like to make?

Dr. Arthur Caplan: No, I think we've gone from the lofty and the highfalutin back down to the basic of let's be led by science. We've had issues with the administration interacting with federal science. I think there there's something to think about whether this group wants to do it or others. You know, it's been an ethical barrier to keep politicians from trying to push science around, whether it's on vaccine approvals or preapproval access or whatever the topic might be.

Politicians understandably want to deliver good news. They want speed. They want a fast answer to what is a devastating plague economically, school-wise, adversely impacting many vulnerable communities. But we may need to legislate there and build better firewalls. It's been a moral agreement so far that we don't bully science. We let the science do what it's supposed to do. I like ethics. I do ethics. I'm an ethicist. But I do think that we may need to build tougher firewalls; otherwise, where Clyde is talking about,

may get subsumed to more political pressure in the future. That's not the best use of science.

Mayor S. Benjamin: I'd say this as we exit. This experience, this pandemic, I'm at home right now although I brought the flags from city hall, so people think I'm working when they see this background. I have a wife who thinks –

Dr. Arthur Caplan: That's the politicians for you.

Dr. Clyde Yancy: There you go. Very clever.

Mayor S. Benjamin: I have a wife who's a judge who is trial right now. I have two beautiful teenage daughters who are upstairs learning from home. Have some repairmen literally up under our house right now. I keep hitting the mute button hoping that you won't hear them making noise right now. The times we're living in have stressed to me, and I think to all of us, the power of humility, the power of not knowing, and not knowing, learning, and understanding where we're going and the importance of constantly learning. That's something that I've done over the last several months and I hope and pray it's made me and each and every one of us a better leader.

What I try to encourage folks, and I'll leave this with you, is that the future is subjective. The future is subjective. That our decisions now will indeed determine our destiny. I tell our citizens that every single day, that we can be one city in one day and we can choose one path of the road less traveled by. And it's amazing what the difference will look like. We'll be able to compare a number of different communities a year or two or five years down the road. So it is going to require this type of amazing dialogue.

I will tell you, just like each of you, I participate in a number of discussions and panel discussions – Laura, Dr. Caplan, Dr. Yancy incredibly elevating and encouraging including all the stuff that we didn't want to hear. The realities that we're facing, seeing this robust group of leaders pointing the right direction leaves me encouraged so thank you. Thank you all.

Laura Gordon: Well, to wrap, I want to read one of the comments in the chat column because I think it says it all. It says, "Incredible panelists. Thank you for your insights and diverse perspectives and provoking our thought. Each frame of reference is important as we tackle these problems." And I'll also quote someone earlier in the chat who said, "These panelists were brilliant." So I leave you with that. I thank you so much for joining us today, for answering the

questions, and sharing such thoughtful perspectives. And I will say I believe we have set the bar quite high for the other panels. So I thank you in helping me do that. So thank you so much for being here with us today. Really appreciate it.

Mayor S. Benjamin: Thank, y'all. God bless you.

Dr. Clyde Yancy: Same to you. Take care.

[End of Audio]