



TELL US MORE

MICHELLE ALBERT '90: Exploring the Biology of Adversity

The pace of life skyrocketed for Michelle Albert '90 when she was 14. Within a year and a half, she emigrated with her family from Georgetown, Guyana, to Brooklyn, New York, tested into high school as a senior, attended college-level courses through a program that primed students from underrepresented groups for careers in medicine, took her SATs and ACTs, submitted her undergraduate applications, and began her freshman year at Haverford.

"It was a lot, and it was fast," she remembers.

Albert graduated with a degree in chemistry at age 20 and hasn't slowed down since. After earning her M.D., she completed training in cardiology, including serving clin-

ical and research fellowships at Brigham and Women's Hospital and Harvard Medical School. There, she met one of her first mentors, renowned cardiovascular epidemiologist Paul Ridker, who helped set the foundation for her career exploring the biology of adversity—or how stressors like racism and poverty influence disease processes.

Now the Walter A. Haas-Lucie Stern Endowed Chair in Cardiology and associate dean of admissions at the University of California at San Francisco School of Medicine, Albert has achieved widespread recognition for her work addressing health disparities. She is the immediate past president of the American Heart Association

AHA), where she was the first person to lead while simultaneously serving presidencies with the Association of University Cardiologists (AUC) and the Association of Black Cardiologists. Before her tenures, no woman of color had ever helmed the AHA or AUC.

Shortly after concluding her AHA term in summer 2023, Albert sat down with *Haverford* to discuss her professional path and priorities.

What drew you to medicine?

This goes back to the working-class environment in which I grew up in Guyana, where I had a front-row seat watching how disadvantages like poverty influence health outcomes. I was raised by my grandparents while my parents were away studying to help support us, and the sudden death of my grandfather from cardiac arrest in a place without adequate healthcare resources specifically spurred my interest in cardiology. This interest went beyond wanting to be a doctor and doing clinical practice—my upbringing made me want to make a difference in the way medicine is taught and the way research gets done to incorporate economic adversity and its impact on health.

When did you begin connecting socioeconomic stress to health on a molecular level?

Initially, I struggled to figure out how to parlay my passions for both science and social issues into an academic career. While in Boston, I was doing population science research on biomarkers of inflammation with my mentor [Ridker], studying how certain chemical molecules predicted cardiovascular risk. Then I began to ask questions like, “OK, we know this molecule predicts risk, but how is it patterned by socioeconomic status? How is it patterned by race and ethnicity?” There are huge disparities in health outcomes based on social context, and I knew looking

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at adversity’s relationship to biology would help us understand the mechanisms responsible for them.

Beyond uncovering those mechanisms, what can be done to reduce disparities?

The answer is complex. First, we need to reform medical education so it prioritizes the social determinants of health just as much as it prioritizes the basic sciences. And it’s not just about teaching; it’s about providing more financial support for research connecting social issues to health.

We also need to do a better job addressing social complexities in the clinic. Let’s say a patient comes in with heart failure. Doctors will collect that person’s history, do a physical exam, and develop a diagnostic plan. But rarely do they ask, “Is this patient able to obtain and take particular medications? What stressors might prevent them from doing what they need to take care of themselves and get well?”

Physicians need to advocate around health equity, whether it’s through scientific work or teaching or policy or supporting diverse persons directly.

What is the hardest part of your job?

I’ve often felt isolated among my peers because cardiologists traditionally have not been interested in the work I do. They are generally more interested in the interventional and clinical aspects of the field. The social topics I research are difficult to swallow and to discuss, plus they’re not topics that get funded easily or that will put you under glamorous bright lights. Limited dedicated funding programs for people interested in doing research around social factors and health exist. The discipline hasn’t been resourced, so people instead gravitate toward work that is incentivized.

You’re a highly regarded mentor. Why is mentoring young physicians important to you?

My mentees actually span the whole spectrum, from pre-medical school to faculty members. Mentorship is not just a top-down thing—it’s a bottom-up thing, and it’s a sideways thing, and it’s never a transactional thing. Some of my mentees are also mentors to me—because we all need help sometimes. But when it comes to mentoring young people, in particular, I see myself as someone who can improve representation in medicine and help grow a more diverse medical workforce, which is important because increasing diversity in healthcare improves the quality of care for those who are socioeconomically disadvantaged as well as Black and brown patients.

What do you do to unwind?

When I’m unwinding, I’m still winding. I love to entertain and to decorate, and I spend a lot of time on Pinterest looking for design inspiration. I’m currently planning an at-home spa party and high afternoon tea for some friends. Everyone who comes to something I host knows they’re going to go home with great party favors. —Karen Brooks