MOVING FROM INJUSTICE TO EQUITY: A TIME FOR THE PHARMACY PROFESSION TO TAKE ACTION

COMMENTARY

The Past, Present, and Futurist Role of the Pharmacy Profession to Achieve Black Health Equity

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Efforts to mitigate racial health inequities by the pharmacy profession are largely hollow. In recent years, the highly publicized murders of Black persons at the hands of police have become a worldwide rallying cry for institutions to make definitive statements that “Black Lives Matter.” The movement has, however, yet to manifest substantive institutional changes for entities to reassess the ways in which they, their methodologies, and their teachings have historically and contemporarily contributed to the dissolution of Black lives. The profession of pharmacy explicitly states it is committed to achieving optimal patient outcomes. However, teaching race as a socio-political construct is not an Accreditation Council for Pharmacy Education (ACPE) minimal standard requirement. This continued neglect is a disservice to the field and the communities served, and this informative article explores the role of pharmacy in perpetuating physical and psychological harm to patients within Black communities. Conflating race with ancestry and approaching race as a simple biological construction/predictor is misinformed, presumptuous, and simplistic, as well as physically and psychologically harmful to patients. Rather than default to racialized historical myths imbedded in contemporary society, pharmacy must answer the call and undertake definitive action to ensure comprehensive education to better care for Black communities. It is vital that schools and colleges of pharmacy actively seek to correct curricular neglect based on negative, pseudo-scientific constructions of “race.” The field of pharmacy must understand its unique positionality within systems of power to adapt a wholistic and accurate view of race and racism to approach, achieve, and maintain health equity in the United States.

Keywords: anti-Black racism, structural competency, health profession education, structural/institutional racism, health inequities

INTRODUCTION

The highly publicized murders of Black persons at the hands of police in 2020 resulted in a worldwide rallying cry for institutions to make definitive statements that Black lives matter.¹ What it has not become, however, is a transformative moment for institutions to reassess the ways in which they, their methodologies, and their teachings have historically and contemporarily contributed to and colluded in diminishing Black lives.

The pharmacy profession explicitly states it is committed to achieving optimal patient outcomes. However,

teaching race as a sociopolitical construction is not even an Accreditation Council for Pharmacy Education (ACPE) minimal standard requirement.² This apparent neglect and denial of the impact of socio-political constructions of race on the lived experiences of Black communities in the United States is a disservice to the field and the communities served. Conflating race with ancestry and approaching race as a simple biological construct is misinformed, presumptuous, and simplistic, as well as physically and psychologically harmful to Black patients.³

In June 2020, Ohio State Senator Steve Huffman (R) was fired from his job as an Emergency Room physician after a legislative hearing wherein he referred to Black Americans as “colored” and suggested rising coronavirus disease 2019 (COVID-19) cases within Black communities was due to questionable hygiene practices.⁴

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Dr. Huffman asked, “Could it just be that African-Americans or the colored population do not wash their hands as well as other groups? Or wear a mask? Or do not socially distance themselves? Could that be the explanation for the higher incidence?” The public was rightfully outraged and immediately suspicious of the quality of care possible by a clinician who was so readily reliant on outdated racist ideas and language. The public should not have been surprised, however, because while health professional schools purport to promote health and well-being, there simply is not a consistent, sustainable plan of education to support this assertion. As Senator Huffman’s experience at the University of Toledo seems to suggest, by *not* disrupting historical and contemporary racist narratives, the university may have inadvertently taught him those presumptions were acceptable and true.

The purpose of this commentary is to summarize missing key elements of current pharmacy education regarding racial health inequities. Specifically, this submission discusses what is jeopardizing Black health, the need to move beyond cultural competency, myths of Black bodies and history of violence by White clinicians, and curricular enhancements to better equip the pharmacy profession with dismantling anti-Black racism and the subsequent Black health inequities.

LITERATURE REVIEW

This commentary is interdisciplinary in that it utilizes knowledge from several fields such as sociology, psychology, history, and medicine, to encourage readers to think across intellectual boundaries in order to view anti-Black racism within the field of pharmacy more comprehensively. Our sourcing revealed myriad, interrelated social and historical factors that jeopardize Black health in the modern era. Moreover, it is clear there is a need to move from mere cultural competency to structural competency, debunk myths associated with Black bodies, address histories of violence by White clinicians, and ensure necessary curricular enhancements for future pharmacy professionals.

FINDINGS

What is Jeopardizing Black Health?

The scientific community has long and well established the fact that biologically speaking, the idea of “race” is of no import and largely unworthy of attention in serious discussions of scientific biology and anthropology.³ Why, then, are colleges, pharmacy organizations, and pharmacy practice mired in ineffective efforts to mitigate racial and ethnic health inequities? Because while

race is a useless social construct, the outdated and ill-informed pseudo-scientific justifications historically used to undergird explanations of physical difference, particularly the non-phenomenon of phenotype, have resulted in tacitly racist presumptions, which have seeped into every facet of the US health profession, including the field of pharmacy.

Infant mortality and life expectancy are important indicators of overall population health. Black infant mortality is two to three times the rate of White infant mortality.⁵ In cities such as Chicago, Black people live 30 years less than their White counterparts.⁶ Without proper framing and knowledge, pharmacists may internalize these racial variances as merely innate or the consequence of a patient’s poor personal choices.⁷ Solely attributing increased prevalence of certain diseases in Black communities to behaviors and biology cultivates Black-White health inequities. Naming structural racism as a public health crisis that harms and kills is necessary in improving Black health.⁸ Structural racism is more than interpersonal interactions; it is embedded in laws, policies, practices, and norms that cause structured disadvantage.⁹ This level of racism should not be ignored as it heavily influences biology, availability of options, and the choices people are capable of making from positions of socio-structural disadvantage.¹⁰ Moreover, models that use genes and personal choices to describe racial health disparities often exclude the impact of racism.

Black bodies are not innately inferior. However, exposure to racism may affect biology by activating pathways that stimulate inflammation, alter genes, and activate pro-inflammatory genes that inhibit the body’s natural defenses to fight off disease.¹¹⁻¹³ These epigenetic changes are not necessarily contained within the individual but may affect subsequent generations.¹³ *Ninety percent* of the history of the United States has included blatant oppression: slavery and segregation.¹⁴ Considering the length (60% of US History, from the first days of Colonial America and enduring through the Civil War) and brutality of chattel slavery, genes might have been modified to activate pro-inflammatory pathways and subsequently inherited. The traumas associated with the unique generational inheritance of witnessing and experiencing normalized violence, eg, being hunted, sold, tortured, raped, mutilated, humiliated, beaten, murdered, and lynched, may have exponentially negatively impacted Black health. Additionally, Jim Crow was only dismantled 50+ years ago, which may explain some of the contemporary health variance seen within the generation that directly experienced Jim Crow and their offspring. Consequently, implicit and explicit racial oppression, past and present, must be robustly interrogated when utilizing a

limited racial-genetic model to describe racial health disparities.

Personal choices alone? Health behaviors are also often used to describe Black-White differences. The salt-sparing effect, for example, and the high salt intake hypothesis have been widely used to describe racial differences in hypertension.¹⁵ This limited explanation neglects that salt reduction reduces blood pressure marginally and little evidence supports that reducing salt intake can explain the Black-White variance. Narrowly focusing on personal choices such as the “unhealthy” African-American diet to describe the Black-White health chasm cultivates systems of inculpability. When Black communities are blamed for the less optimal health outcomes they experience, there is no need to interrogate and dismantle systems of power that create structural vulnerabilities to health.

The Need to Move From Cultural Competency to Structural Competency

Eliminating Black health inequities necessitates acknowledging the racist historical roots of the United States. However, it may be difficult for some White US Americans to acknowledge racist roots because of White fragility.¹⁶ Instead, ideologies often assumed within academic institutions and taught to generations of health professionals include a narrow focus on individuals to describe disparities, ignoring structural root causes, an anti-historical stance, myth of meritocracy, myth of US exceptionalism, and White supremacy.¹⁷ Performative displays of mitigating health inequities usually involve knowledge expansion regarding social determinants of health without discussing racism or the various institutions that structure opportunities away from Black communities, such as secure housing, healthy meals, well-funded public schools, discretionary income, robust wealth, and incarceration.

Structural competency identifies the impact of structural inequities on health and health care as well as generates interventions external and internal to clinical interventions. It is time for the Academy to move beyond lifestyle modifications as a path to optimal health. “Healthy” choices are hard goals to achieve for communities structured to live in concentrated poverty and experiencing chronic stressors. It is significantly easier for communities to make better choices if they have access to better choices, such as neighborhood grocery stores, accessible public transportation, affordable housing, livable wages, and dignity. The pathway to better health is not through blaming Black communities for increased prevalence of certain diseases but dismantling systems that structure opportunity away from optimal health. Interventions are needed that look beyond behaviors and

biology and towards the structural forces that cultivate morbidity and mortality.

Required elements of the Doctor of Pharmacy curriculum include teaching cultural awareness to explore “the potential impact of cultural values, beliefs, and practices on patient care outcomes.”² However, focusing on culture misses structural forces. Furthermore, implementing solutions at the individual level diverts time, attention, and energy away from transforming colleges of pharmacy, pharmacy organizations, and pharmacy practice. Promoting structural competence involves minimizing fragility and guilt; skepticism of race-based differences; collaborating with other professionals to provide social determinants of health such as food, transportation, and housing; practicing at the intersection of social sciences and humanity; researching evidence-based structural interventions; valuing and advocating for Black lives; understanding race as a socio-political construction; naming historical and contemporary racism; applying resources equitably; and diminishing bias to see patients holistically.^{18,19} Pharmacy must understand how historical structural inequities such as slavery, the Thirteenth Amendment, and Jim Crow continue to impact the distribution of the social determinants of health and consequently contemporary health.

The history of violence by White clinicians to devalue Black lives in America is as old as the nation itself.^{20,21} The social conditions and human costs embedded in the Atlantic slave trade created physical and psychological terror for enslaved adults, children, teens, infants, individuals who are nursing, and the elderly, setting a New World precedent for the clinical treatment of human beings viewed as commercial commodities.²² Ship surgeons employed ghastly medical practices and procedures on the hands, arms, chests, torsos, genitalia, hips, muscle-torn thighs, heads, necks, faces, knees, shins, calves, and breasts of the enslaved in an effort to maximize commercial profit, regardless of the human cost.

For more than 200 years the most advanced clinical minds in the civilized world employed torturous techniques and methods against the wholly vulnerable.^{23,24} During the slave era, erroneous presumptions permeated the clinical community regarding Black bodies (eg, thicker skin, impervious to pain, ‘weak lungs,’ ‘strong immunities,’ ‘weak immunities,’ large sex organs, small skulls).

Extra-legal policing tactics and methods, biased judicial outcomes, and disproportionate incarceration rates of Black persons in America are not novel social justice crises.¹⁴ In the 17th and 18th centuries, Colonial legislatures adopted laws designed to position enslaved Africans and their progeny to lifelong and perpetual servitude. In the 19th century, well after the national transition from colonies to sovereign nation, the United States Supreme Court

famously denied the rights of Blacks to lay any claim to Constitutional rights and protections. According to the majority opinion in *Dred Scott v Sanford* in 1857, the Founding Fathers never intended to include Black persons as “citizens.”²⁵ Emancipation, the failures of Reconstruction, and the first widespread movement of Black bodies from the agricultural South to the North and West during the so-called Progressive Era, did nothing to stem longstanding racialized practices that characterized the uniquely American social milieu of normalized brutality against Black bodies.

Whereas traditional veins of national history define the turn of the 20th century as an era of widespread social activism and political reform, specialists in African American history rightfully recognize the same time as the *nadir* (low point) of race relations in the national narrative.²⁶ Sharecropping and the Ku Klux Klan in the South, race riots in newly urbanized communities such as Detroit, Chicago, and Cincinnati, and the nationwide scourge of lynching were the hallmarks of Black, second-class citizenship. At every moment in this troubled past, the health care community supported damning practices that reaffirmed the national devaluation of Black bodies through gruesome medical experimentation, dangerous clinical trials, and live surgical demonstrations, without compensation at best, or anesthesia at worst. These historical realities have meaning, import, and a direct connection to contemporary racial and ethnic health inequities in the United States.

Myth of Black Bodies and History of Violence by White Clinicians

Although racism intersects and overlaps across various institutions to produce widespread inequalities, it is necessary for pharmacists to examine how racism, past and present, shows up in health care. Thomas Jefferson, a founding father of a country built on an “all men are created equal” ideology, used research from science and clinical communities to reconcile the contradiction of the Declaration of Independence with the institution of slavery.

Thomas Jefferson declared, “that the blacks, whether originally a distinct race, or made distinct by time and circumstances, are inferior to the whites in the endowments both of body and mind. This unfortunate difference of colour, and perhaps of faculty, is a powerful obstacle to the emancipation of these people”²⁷ He justified slavery as natural by arguing that Black persons sweated more than their White counterparts which allowed them to be more “tolerant of heat” and “require less sleep.”²⁷ Additionally, he asserted they were intellectually inferior, “their

existence appears to participate more of sensation than reflection.”²⁷ He likened them to animals and asserted, “To this must be ascribed their disposition to sleep when ... unemployed in labour. An animal whose body is at rest, and who does not reflect, must be disposed to sleep of course.”²⁷ His ideologies would be utilized by clinicians to reinforce Black oppression.

Clinicians often narrowly focused on individuals vs cultivating systems of equity. Dr. Murrell detailed the “syphilitic negro” in ways that are often used contemporarily to describe Black health inequities: non-adherence, “Even among the educated, only a very few will carry out the most elementary instructions as to personal hygiene”; poor personal choices, “A negro man will not abstain from sexual intercourse if there is the opportunity and no mechanical obstruction”; and appalling morals, “The spread of venereal disease is dependent, to some extent, at least, on the moral status of the race, and the morals of the negro is something of which the average man of other climes has no conception.”²⁸

The Tuskegee Study of Untreated Syphilis is a well-known inhumane study conducted over a span of 40 years from 1932-1972 to prove that neurological manifestations of syphilis would bypass Black people.^{23,29} Unfortunately, this study was built upon previous racist clinical research describing the supposed minimal intellectual capacity and oversexualization of Black persons. Although syphilis impacted Black and White people, physicians argued this disease was due to the poor morals of Black communities. Dr. Daniel D. Quillian alleged, “In a practice of sixteen years in the South I have never examined a virgin negro over 14 years of age.”²⁹ Instead of maximizing equitable societies to minimize the spread of infectious diseases in Black communities, clinical experts relied on racial stereotypes to sacrifice Black health.

In addition to structuring opportunity away from Black communities, clinicians were involved in halting and pathologizing Black resistance. With the emancipation of slavery, clinicians used medical journals to criticize and problematize liberation. Medical journals published manuscripts describing the problem of the “emancipated negro.” In 1903, Dr. Seale Harris published tuberculosis scholarship in the *Journal of the American Medical Association*, a well-respected medical journal, “That consumption is almost a scourge to the emancipated negro ... the only reason why it was not so with the slaves was that their habits and sanitary surroundings were better than those of many of their masters.”³⁰ Dr. Murrell also explored “the negro problem” in that same journal in 1910, discussing syphilis, “If the healthy negro is a political menace, then the diseased one is doubly a social menace, and the invasion of the South by the North forty years ago has brought

about an invasion of the North, and that by the man they freed.”²⁸

Dr. Cartwright, an “expert on Negro medicine” and well-respected slavery apologist, declared that Black individuals had diminished lung capacity requiring forced labor: “It is the red, vital blood, sent to the brain, that liberates their mind when under the white man’s control; and it is the want of a sufficiency of red, vital blood, that chains their mind to ignorance and barbarism, when in freedom.”²³ Of note, he created a spirometer to study Black-White lung differences. The deficiency he noted is still used in updated versions with misguided race corrections.

Dr. Cartwright characterized in a widely circulated paper, “Report on the Diseases and Peculiarities of the Negro Race,” that *drapetomania* is a “disease causing negroes to run away” which required “whipping the devil out of them.”³¹ He also termed another mental illness, *dysaesthesia aethiopica*, caused by “negro liberty—the liberty to be idle, to wallow in filth, and to indulge in improper food and drinks.”³¹ He stated this disease “is much more prevalent among free negroes living in clusters by themselves, than among slaves on our plantations, and attacks only such slaves as live like free negroes in regard to diet, drinks, exercise, etc.”³¹ According to Dr. Cartwright, this disease increased the likelihood that individuals will “do much mischief, which appears as if intentional, but is mostly owing to the stupidity of mind and insensibility of the nerves induced by the disease. Thus, they break, waste and destroy everything they handle ... They wander about at night, and keep in a half nodding sleep during the day. They slight their work—cut up corn, cane, cotton or tobacco when hoeing it, as if for pure mischief. They raise disturbances with their overseers ... without cause or motive, and seem to be insensible to pain when subjected to punishment.”³¹

One-hundred years after the dismantling of slavery, health professionals continued to protect white power structures. Similar to Dr. Cartwright, the profession of psychiatry in the 20th century pathologized Black resistance as a mental illness.^{18,23} Because of the structural shift in the characterization of schizophrenia, Black people became disproportionally diagnosed with schizophrenia. *The Diagnostic and Statistical Manual* went from describing schizophrenia as emotional disharmony reserved typically for middle class white women to a condition associated with hostility, aggression, violence, and anger.¹⁸ The implications of using these racially charged descriptors meant that there was a significant increase in Black people receiving this diagnosis. Clinical racism often intersects and overlaps with other institutions (eg, media, policing) to produce widespread inequities. Consequently, advertisements used angry Black men as the face

of their campaigns with language such as, “Assaultive and belligerent? ... Cooperation often begins with Haldol ... Acts promptly to control aggressive, assaultive behavior.”¹⁸ After being arrested for minor offenses, psychiatric institutions began to fill with Black men diagnosed with delusion, paranoia, and hostility.

Optimal health is not found in better choices but in better opportunities. However, clinicians are complicit in continuing problematic narratives that health disparities exist because Black people engage in unhealthy behaviors or are genetically inferior. Critical thinking falls short across various disease states such as pain and substance use disorders.

Racial physiological myths—endorsed by White clinicians and perpetuated since the era of slavery—that Black bodies can tolerate more pain due to thicker skin produce less accurate treatment decisions.³² Compared to their White counterparts, Black patients, from children to elders, receive inadequate pain management (eg, tonsillectomies, large bone fractures) in a variety of settings (eg, hospice care).³³

Dr. Susan Moore, a Black physician battling COVID-19, went to Facebook in December 2020 detailing her horrid health care experience.³⁴ She described how she “begged” for diagnostics, physical examinations, treatment, and care of her pain. Sadly, Dr. Moore died two weeks later. Even in death, she was blamed for her mistreatment and not spared from stereotypical depictions of Black women. The Chief Executive Officer (CEO) of the health system providing her care stated the staff “may have been intimidated by a knowledgeable patient.”³⁵ Despite Dr. Moore’s personal account of her egregious experience, the CEO of this organization “committed to equity” proclaimed, “I do not believe that we failed the technical aspects of the delivery of Dr. Moore’s care.”

In the field of obstetrics, contemporary racialized beliefs regarding substance use disorders have a direct correlation to attitudes from the era of slavery that Black child-bearers are irresponsible and neglectful.¹⁸ For instance, a state hospital that served people of color implemented a policy, Interagency Policy on Cocaine Abuse in Pregnancy, to non-consensually drug test pregnant patients. If patients tested positive, they were arrested on charges of child abuse or distribution of drugs to a minor. Patients were transported inhumanely in shackles for prenatal care. Patients were even handcuffed to the bed during painful deliveries. Some patients were arrested and separated from their newborns within hours of giving birth. This inhumane and discriminatory policy criminalized substance disorders to target Black child-bearers as they made up all but one arrest.

These types of drug screening protocols were uniquely positioned in public hospitals to criminalize race and poverty.¹⁸ Despite similar rates of drug use, clinicians were 10 times more likely to report Black patients to authorities than White patients. The racist attitudes that Black child-bearers were “welfare queens,” irresponsible, uncaring, ruining Black families, and birthing “crack babies” (an accusation that was scientifically unfounded) cultivated the creation of these policies. These attitudes were reinforced by various institutions, health professionals, health systems, and health journals producing disproportional amount of research regarding the effects of crack cocaine compared to heroin.

Curricular Enhancements

In the 21st century, clinical practices are still informed by racist practices, attitudes, research, and beliefs of the past. In order to eliminate racist clinical practices, a deeper understanding of social, economic, and political drivers to health should feature prominently in the education of pharmacy students and the re-education of pharmacists. To ensure students actively comprehend and work to dismantle the web of structural inequities in the United States, pharmacy programs across the nation could implement structural competency in their curriculum, which would ensure student instruction on the social, political, and economic factors that differently affect the lives and health of Black patients.

A sample four-year PharmD curricular intervention could include a “Pharmacy Practice for Health Equity” course that includes sample readings and yearly goals as presented in Tables 1-4.^{14,18,22,23,36-49} These required, layered courses threaded throughout the curriculum would

include knowledge expansion of bias and structural inequities as well as skill development through experiential learning to implement structural interventions. Additionally, pharmacy accreditation standards described in ACPE’s Standards 2016 can also be modified to include explicit language regarding evidence-based, transformative anti-bias education in Standard 4: Personal and Professional Development; impact of historical and contemporary structural inequities in the distribution of the social determinants of health in Standard 3: Approach to Practice and Care; and implementing structural interventions in Standard 2: Essentials for Practice and Care.² Moreover, changing *cultural sensitivity* to *systems of power* in Standard 3 will systematically ensure the multiple levels of racism, as well as patriarchy, queer antagonism, fat hostility, and other inequities within the US context and globally, will be taught in schools and colleges of pharmacy. The authors are optimistic this manuscript will provide the tools and motivation to make changes within pharmacy.

DISCUSSION

At its essence, this paper argues for targeted and sustained educational practices to dismantle racialized ignorance by health professions generally and in pharmacy specifically. The necessity of this education for pharmacists is not mere theory, as is evident in the words, blithe use of outdated pejorative language, and actions of clinicians. These actions have cultivated rightful mistrust of Black communities towards health professionals who remain reliant on racist ideologies and language. The pharmacy profession must evolve to protect patients from bias and structural inequities with targeted educational measures to

Table 1. Sample Four-year PharmD Pharmacy Practice for Health Equity Course: Year 1

Year 1 - PPD1: Awareness (Standard 4)
Learning outcome: Students engage in self-awareness to recognize their positionality within systems of power
Semester 1: Bias, Stereotypes, Microaggressions, and Interpersonal Power Dynamics
<u>Sample Readings</u>
Avant ND, Penm J, Hincapie AL, Huynh VW, Gillespie GL. “Not to exclude you, but ...”: characterization of pharmacy student microaggressions and recommendations for academic pharmacy. <i>Curr Pharm Teach Learn</i> . 2020;12(10):1171-1179. ³⁶
Singh AA. Transgender youth of color and resilience: negotiating oppression and finding support. <i>Sex Roles</i> . 2013; 68(11-12):690-702. ³⁷
Chen HA, Trinh J, Yang GP. Anti-Asian sentiment in the United States - COVID-19 and history. <i>Am J Surg</i> . 2020;220(3):556-557. ³⁸
Semester 2: Systems of Power
<u>Sample Readings</u>
Cooper B. <i>Eloquent Rage: A Black Feminist Discovers Her Superpower</i> . St. Martin's Press, 2018. ³⁹
Strings S. <i>Fearing the Black Body: The Racial Origins of Fat Phobia</i> . NYU Press; 2019. ⁴⁰
Patton S. <i>Spare the Kids: Why Whipping Children Won't Save Black America</i> . Beacon Press; 2017. ⁴¹

Table 2. Sample 4-year PharmD Pharmacy Practice for Health Equity Course: Year 2

P2 - PPD2: Social and Structural Determinants of Health (Standard 3) Learning outcome: Students learn to look beyond biology and behaviors to understand differential health outcomes

Semester 1: The history of structural inequities (eg, slavery, red-lining, Jim Crow, 13th Amendment) in the US

Sample Readings

Berry DR, Gross KN. *A Black Women's History of the United States*. Beacon Press; 2020.¹⁴

Mustakeem SM. *Slavery at Sea: Terror, Sex, and Sickness in the Middle Passage*. University of Illinois Press; 2016.²²

Nuriddin A, Mooney G, White AIR. Reckoning with histories of medical racism and violence in the USA. *Lancet*. 2020;396(10256):949-951.⁴²

Skloot R. *The Immortal Life of Henrietta Lacks*. Picador; 2018.⁴³

Semester 2: The distribution of the social determinants and the impact on health

Sample Readings

Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and structural determinants of health inequities in maternal health. *J Womens Health (Larchmt)*. 2021;30(2):230-235.⁴⁴

Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *Lancet*. 2017;389(10077):1453-1463.⁴⁵

Miller J, Garran AM. The web of institutional racism. *Smith Coll Stud Soc Work*. 2007;77(1):33-67.⁴⁶

Table 3. Sample 4-year PharmD Pharmacy Practice for Health Equity Course: Year 3

P3 - PPD3: Reimagining Clinical Interventions, Practice, Policy, and other Structural Interventions (Standard 2) Learning outcome: Students develop a deeper understanding of structural awareness and review various structural interventions that have mitigated health disparities

Semester 1: Importance of structural awareness

Sample Readings

Metzl JM, Roberts DE. Structural competency meets structural racism: race, politics, and the structure of medical knowledge. *Virtual Mentor*. 2014;16(9):674-690.¹⁸

Avant ND, Gillespie GL. Pushing for health equity through structural competency and implicit bias education: a qualitative evaluation of a racial/ethnic health disparities elective course for pharmacy learners. *Curr Pharm Teach Learn*. 2019;11(4):382-393.⁴⁷

Roberts D. *Fatal Invention: How Science, Politics, and Big Business Re-Created Race in the Twenty-First Century*. New Press; 2012.²³

Semester 2: A review of approaches to dismantle structural inequities to improve health

Sample Readings

Pallok K, De Maio F, Ansell DA. Structural racism - a 60-year-old Black woman with breast cancer. *N Engl J Med*. 2019;380(16):1489-1493.⁴⁸

Hansen H, Metzl J, Ohio Library and Information Network. *Structural Competency in Mental Health and Medicine: A Case-Based Approach to Treating the Social Determinants of Health*. Cham, Switzerland: Springer; 2019.⁴⁹

Table 4. Sample 4-year PharmD Pharmacy Practice for Health Equity Course: Year 4

P4 - PPD4: Capstone Project: Creating Structural Change (Standards 2-4)

Learning outcome: Students demonstrate ability to implement structural interventions

Students can complete this requirement via:

Advanced pharmacy practice experience structural competency rotations (ie, teaching, clinical practice, community engagement, policy advocacy).

Independent research (eg, facilitate community based participatory research to capture the distribution of the social determinants of health).⁴⁷

address a myriad of “worst practices” seemingly inherent of health professionals. Current curriculum offerings and requirements for students enrolled in pharmacy programs are sorely lacking in explicit conversations regarding the

socio-political impacts of race in the United States on Black communities.² In neglecting to teach rising professionals to recognize, through sustained curricular changes, enhancements, and instruction, the impacts of racism on the lived

experiences of Black people in the United States, pharmacy remains one of many that erroneously suggests those factors simply do not matter when it comes to contemporary health disparities.

At the time of this writing, the pharmacy Academy has not released consistent and sustainable plans of education to mitigate racialized ignorance. By *not* disrupting historical and contemporary racist narratives, pharmacy inadvertently teaches racial presumptions are acceptable and true. Pharmacy can no longer continue to ignore the socio-political impacts of race in the United States on Black communities and must take affirmative and immediate action to re-educate learners to recognize that these factors do, indeed, matter.

Race is not biological, but *racism* is real. So real, in fact, that in June 2020 the American Medical Association (AMA) defined racism as a threat to public health. Specifically, the AMA recognizes “racism, in its systemic, cultural, interpersonal and other forms, as a serious threat to public health, to the advancement of health equity and a barrier to appropriate medical care.”⁵⁰

SUMMARY

It is imperative that pharmacists become structurally competent to mitigate Black inequities and acknowledge the role of health professionals in implicitly and explicitly oppressing Black people. Viewing health at the intersection of trauma, oppression, and socio-structural determinants of health is a small step necessary in this fight to achieve equity. Schools and colleges of pharmacy should at the very least ensure they are graduating structurally competent pharmacists.

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