THEME ISSUE: Health Disparities and Cultural Competence Content in the Pharmacy Curriculum

Introduction to Implementing Health Disparities and Cultural Competence Content in the Doctor of Pharmacy Curriculum

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The 2013 American College of Clinical Pharmacy (ACCP) White Paper by O’Connell and colleagues introduced instructional approaches and resources for assessing health disparities and cultural competence training within the pharmacy curriculum. Instructional standards, such as the Accreditation Council for Pharmacy Education (ACPE) Standards 2016, have been updated to state the importance of teaching “cultural awareness” and exposure to “diverse populations” within pharmacy curricula. There remains a gap in understanding how various programs should implement these concepts. To ensure that the knowledge students learn is meaningful, it is critical for approaches to HDCC education to be intentional, integrative, and comprehensive. Without this type of approach, students may lose key skills and be unable to deliver culturally responsive, patient-centered care upon graduation. In this theme issue, three papers will introduce areas for HDCC inclusion and explore how these topics are currently being covered in pharmacy education. Recommendations on best practices are provided.

Keywords: pharmacy education, cultural competency, curriculum, cultural humility, health disparities

INTRODUCTION

Health disparities (HD) and cultural competence (CC) have been recognized as a critical aspect of clinical training in health sciences disciplines. With the social justice movement peaking amid health disparities uncovered during the COVID-19 crisis and highly publicized incidents of police brutality, the demand for centering pharmacy education around HDCC concepts has intensified. The ACPE Standards 2016 introduce cultural awareness as an outcome that students should develop by graduation to be deemed practice-ready pharmacists. Cultural sensitivity is specifically noted in standard 3.5, which infers that HD, health inequities, and social determinants of health should be integrated into the curriculum. Preceding publications have aired apprehension about the methodologies used to teach HDCC concepts in schools and colleges of pharmacy. A recent study revealed that US and Canadian pharmacy schools do not have a systematic approach to integrating HDCC content across the curriculum. Instead, topics are often taught by select faculty in individual, sometimes randomly selected, courses or experiences, and there is not a universal assessment approach. To ensure coherence, HDCC topics should be aligned across professional years using techniques such as scaffolding or spiraling, which tie constructs together and build upon prior teachings. Integration into multiple subject or practice areas coupled with appropriate assessment is also important to ensure that students are being taught according to instructional standards. A targeted assessment approach can be used to evaluate achievement of learning objectives, progression of knowledge and skills, and identify gaps or redundancies throughout didactic, co-curricular, interprofessional, and experiential areas of the curriculum. The papers in this theme issue will emphasize best practices for teaching and assessing HDCC in pharmacy schools.

The theme issue consists of four papers, including this introduction, that address needs related to HDCC content: An overview of the papers, the need for a programmatic approach, curriculum and co-curriculum, and assessment tools. These foci were deemed appropriate for this issue based on the authors’ intended purpose of addressing HDCC incorporation in pharmacy education as a means of training a new cadre of pharmacists who are more ready to deliver culturally responsible and equitable care.

This introductory paper provides an overview of the concepts discussed in the aforementioned series of papers.
Key terms used throughout the series will be defined and discussed, and general methods explained. This themed issue is intended to serve as a resource for schools and colleges of pharmacy to identify opportunities for HDCC inclusion, and as a call to action for the Academy to move past siloed implementation of HDCC curricular methods.

Health Disparities and Cultural Competency Terms

Health disparities are modifiable factors that prevent individuals in marginalized groups from achieving their ideal health. These factors are directly related to systematic or structural barriers and the imbalanced dissemination of social, political, environmental, or economic resources. In general, a health care disparity is the result of differences that are not explained by quality of care, access to care, and insurance coverage. Often, health disparities result from more than one factor, which may include poverty, environmental threats, inadequate access to health care, behavioral factors, and educational inequities. Disparities can occur based on one’s race, ethnicity, socio-economic status, age, geographical location, gender, disability status, sexual orientation, or other factors. There is increasing evidence demonstrating that systemic barriers are continuing to lead to harmful outcomes. Most people are aware of the Tuskegee experiments that targeted Black men, but science has often also come at the expense of women of color as demonstrated in the Puerto Rican birth control trials. Most recently, data have shown that racial and ethnic groups are being disproportionately affected by COVID-19. Health disparities not only affect the groups who are facing these disparities, but also limit equitable quality of care among all populations. The terms health inequalities and inequities have sometimes been used to denote systematic differences in health that could be avoided by reasonable means as they are both preventable and unnecessary.

Cultural competence is “the awareness, knowledge, skills, and processes needed by individuals, professions, and organizations to function effectively and appropriately in culturally diverse situations.” Examples of skills that this may involve include verbal and nonverbal communication, professional development, management, and evaluation. An important reason for cultural competence is to achieve the highest quality of care and produce better outcomes for all patients, regardless of their cultural background.

Cultural humility is defined by Tervalon and Murray-Garcia as a commitment to a lifelong process of self-reflection and self-critique that individuals enter with patients, communities, colleagues, and themselves. Cultural humility differs from cultural competence. Cultural competence encourages the knowledge and respect of identities, but cultural humility encourages the lifelong learning of all aspects of the lived experience. Humility requires that a person also examine their own background and beliefs to determine how those have shaped their experience and use this knowledge to address power imbalances.

METHODS

This themed issue was developed using several methodologies. An extensive literature review was conducted using Medline, ESBSCOhost, Google Scholar, PubMed, and the International Pharmaceutical Abstracts database. The search used the following keywords and combinations of keywords: cultural competency, cultural diversity, health care disparities, health status disparities, pharmacy education, curriculum, co-curricular, interprofessional education, multiculturalism, cross-cultural, diversity education, intercultural, and cultural empathy. The search was limited to publications between 2000 and 2020. However, to be inclusive of frameworks and terminology with current relevance but early origins, certain articles were dated prior to 2000.
For one manuscript, the authors conducted a search of individual journal websites (American Journal of Pharmaceutical Education, Currents in Pharmacy Teaching and Learning, Pharmacy Education, Journal of the American College of Clinical Pharmacy, American Journal of Health System Pharmacy) using relevant terms. Articles were excluded if they did not provide sufficient detail on HDCC concepts or strategies for teaching health professions students or the assessment tools used to measure a specific learning experience; the study sample was not located in the United States; did not have a direct applicability to the role of pharmacists or could not be applied to pharmacy students; or there was insufficient information on about the tool’s reliability or validity since 2010. Examples of information resources included in online searches were the ACPE 2016 Standards, the Centers for Disease Control and Prevention (CDC), Institute of Medicine (IOM), Agency for Healthcare Research and Quality (AHRQ), Organisation for Economic Co-operation and Development (OECD), National Conference of State Legislatures, Association of American Medical Colleges (AAMC), and Joint Commission of Pharmacy Practitioners (JCPP). The authenticity of information found on referenced websites was evaluated by the co-authors for accuracy, relevance, scope, and validity. Authors from the AACP Health Disparities and Cultural Competence Special Interest Group (SIG) with expertise in the field were recruited to write this themed issue as part of their strategic plan to address contemporary needs related to HDCC in pharmacy education. Experts in the fields of education and assessment were also recruited to contribute to the manuscripts.

SUMMARY

The demand for a more holistic and comprehensive approach to HDCC in pharmacy education is accelerating. Because all pharmacy disciplines (practice, social and administrative sciences, and pharmaceutical sciences) can contribute meaningfully to the incorporation of curricular and co-curricular content, this programmatic approach will best ensure that HDCC content is introduced and reinforced throughout all academic areas. Though implementing this process may be challenging because of the predominance of traditional teaching and assessment methods, it is a required step for addressing systemic barriers within the profession and inequities in health care.

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REFERENCES