

## COMMENTARY

### Five Essential Steps for Faculty to Mitigate Racial Bias and Microaggressions in the Classroom

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Educators must recognize the pharmacy curriculum itself is an instrument that can propagate or discourage systemic racism. The role of pharmacy education in disseminating racial bias through didactics deserves further consideration. While microaggressions have begun to be acknowledged in the pharmacy learning environment, specific guidance on mitigating racial microaggressions in the classroom has not been provided. This paper aims to suggest actionable strategies pharmacy educators may use to mitigate or prevent these negative classroom experiences. As such, it combines five experiences of racial biases and microaggressions in the classroom with suggested action items in a practical guide for pharmacy faculty members. It is our hope that this commentary will challenge faculty to self-assess their teaching, with the aim of preventing racial biases from propagating and creating better learning environments for future pharmacists.

**Keywords:** diversity, inclusion, bias, microaggression

#### INTRODUCTION

On May 25, 2020, George Floyd was murdered by a police officer—a seminal incident that shook the nation. The weeks of worldwide protests that took place in the aftermath of his horrific death as well as the murders of Breonna Taylor, Amaud Arbery, and countless others reflected resistance to the violent treatment of Black people by law enforcement across the United States. During this racial reckoning, the COVID-19 pandemic also unveiled the stark racial disparities in our health care system through disparities in rates of infections, deaths, and immunizations. Many will remember 2020 as the year of the COVID-19 pandemic or the year we worked from home, but others will also remember this historic time as the year when the nation realized it could no longer turn a blind eye to the ongoing pandemic of systemic racism.

The American Association of Colleges of Pharmacy (AACCP) has long supported equity, diversity, and inclusion.<sup>1</sup> This past year, there was a renewed fervor for discussions on wide-ranging topics in this arena, from diversity, equity, and inclusion to privilege, anti-racism, implicit/unconscious bias, and the social determinants of

health, with many sessions provided by pharmacy professional organizations. Through this programming, there were numerous calls to action for pharmacy educators to become more aware of biases and recognize the existence and effects of systemic racism. However, as educators know, the steps in Bloom's taxonomy that follow knowledge and understanding are application, analysis, evaluation, and creating.<sup>2</sup> In other words, now is the time for *action*.

Action steps to address systemic racism in pharmacy practice have been suggested, but the role of pharmacy education, specifically in Doctor of Pharmacy (PharmD) programs, in disseminating racial bias deserves further consideration.<sup>3</sup> Educators must recognize the pharmacy curriculum itself is an instrument that can propagate or discourage systemic racism.<sup>4</sup> For example, studies have shown that the medical curriculum has historically oversimplified race and disease presentation, contributing to diagnostic and treatment bias.<sup>4,5</sup> Studies have also shown that despite expressed commitment to caring for the medically underserved upon entering medical school, medical students display increasingly negative attitudes toward the medically underserved during the four years of medical school curriculum.<sup>6</sup> While research on this topic in pharmacy is scarce, an exploratory study of the experiences of underrepresented racial minority pharmacy students found that they felt the curriculum "perpetuated the social

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hierarchy” and was a “continuous representation of White people.”<sup>7</sup> This bias in curriculum is likely transmitted unconsciously, without malicious intent. The learning environment is impacted by the didactic curriculum as well as the “hidden curriculum,” namely the curriculum of unplanned values, beliefs, and norms that is learned by students all the same (ie, “unwritten rules”).<sup>8</sup> Nevertheless, the way race is portrayed in pharmacy school can have unintended consequences of negative classroom experiences.

Students’ experiences of racial microaggressions in health professional programs have also been described.<sup>9,10</sup> Microaggressions, defined as a subtle, powerful, and often unintentional form of discrimination, have implications for the wellness and success of students of racial/ethnic minorities.<sup>11</sup> Types of racial microaggressions are wide-ranging and include assumptions of lesser intelligence, of criminality or dangerousness, or that one’s cultural background and communication styles are pathological; they also involve environmental cues of being unwelcome or devalued.<sup>12</sup> Microaggressions like these and other understated indignities reveal biases and send messages that cumulatively result in students feeling “othered” and out of place.<sup>12</sup> While microaggressions have begun to be acknowledged in the pharmacy learning environment, specific guidance on mitigating racial microaggressions in the classroom has not been provided. It is important to recognize that pharmacy education has historically been predominately White. In the United States, underrepresented minorities account for 33% of the population but only 17% of all students enrolled in PharmD programs.<sup>13</sup> The profession is lacking in diversity, not only in student pharmacists but also in pharmacy faculty.<sup>13</sup> This has the potential to further marginalize students beyond society’s daily impact. Students historically navigate through these isolating experiences alone or by leaning on one another through systems of social support, but faculty also have an opportunity to work to improve the classroom environment through intentional efforts to reduce the dissemination of bias.<sup>7,14</sup>

This paper aims to suggest actionable strategies pharmacy educators may use to mitigate or prevent the microaggressions triggered by these negative classroom experiences. The perceived biases and microaggressions described in this paper have been exhibited by well-meaning educators and genuinely nice people. These experiences have also been reported in other areas of higher learning. However, it is our specific aim to frame these concepts in an actionable and practical manner.

In Appendix 1, five experiences of racial biases and microaggressions in the classroom are combined with suggested action items to provide a guide for pharmacy faculty. This guide includes a list of things to avoid, essentially a “what not to do” list, supported by examples; it also

includes recommendations for what to do instead, a “how to do it differently” list. It is our hope that this Commentary will challenge faculty in self-assessing their teaching, to prevent propagating racial biases and create better learning environments for future pharmacists.

## DISCUSSION

This guide is not meant to be accusatory or to suggest that educators who do not currently employ these tactics are inherently racist or bigoted. The issues highlighted above are often not deliberate and may seem innocuous to many. However, lacking an understanding of how these actions may be perceived can have unforeseen consequences. Despite strides in recruiting minority students, pharmacy has made virtually no progress in increasing the proportion of underrepresented minority faculty in the last 20 years.<sup>13</sup> This is concerning, as the presence of minority faculty is a strong facilitator for students’ sense of belonging.<sup>7</sup> Through role modeling, students absorb information about what is valued, acceptable, or possible. By overlooking or not confronting social norms, faculty may inadvertently allow pervasive racial biases to be maintained and reinforced. Critics of these initiatives may continue to dismiss microaggressions as students being “oversensitive,” but it is important to emphasize that microaggressions are not about just having hurt feelings. Rather, microaggressions produce negative effects related to being repeatedly slighted, invalidated, alienated, and dismissed at both a micro (biological) and macro (social) level.<sup>15</sup> According to a nationwide study of medical students, those who described experiencing microaggressions reported decreased satisfaction with school, were more likely to consider medical school transfer or withdrawal, were less likely to want to stay at their institution for residency, and were less likely to recommend their school to friends.<sup>11</sup> Negative racial experiences within the pharmacy learning environment may also discourage qualified practitioners of minority racial/ethnic backgrounds from seeking careers in pharmacy education, negatively impacting aspirations to increase faculty diversity.

As an Academy and profession committed to increasing diversity, mitigating racial bias and microaggressions in the classroom is of utmost importance. However, we recognize that many barriers exist to effectively engaging race in the classroom. As faculty, it can be difficult to apply new knowledge to current teaching philosophy or teaching styles; it is challenging to unlearn the way one was trained or to adjust the materials one has already created. It can seem time-consuming or even overwhelming to be mindful of or intentional about creating an inclusive classroom environment while juggling all of one’s other

scholastic responsibilities. Willen, a medical anthropologist, summarizes the four essential challenges of teaching about issues of race and ethnicity in the classroom, which are that the didactic nature of clinical training tends to simplify rather than complicate; that the universalizing biomedical gaze tends to ignore cultural and social differences relevant to clinical practice; that clinicians and clinical trainees are reluctant to make themselves vulnerable by openly sharing with others their own discrimination experiences or invisible privilege; and that it is challenging to craft a safe space or hold an environment in which different people are willing to engage with the deep unresolved emotions tied to cultural and racial issues.<sup>16</sup> The simple, practical adjustments outlined in this appendix may help to change some of the subtle messages conveyed in the pharmacy curricula and learning environment. Additionally, institutional support to create space for critical self-reflection, additional training, and faculty development in the form of case-based workshops facilitated by experts in the field is recommended to develop an understanding of the impact of implicit biases and microaggressions as well as strategies to address them.

Of note, the table is not intended to be a catchall for inclusive classroom teaching but rather a baseline starting checkpoint of sorts for faculty interested in investing sincere effort into making their classrooms more inclusive for all students. This work also does not detail the racial biases and microaggressions that may occur within team-based learning (such as being ignored or silenced, enduring insulting jokes/comments, or fearing being stereotyped when expressing concerns [ie, angry Black woman]), within experiential settings (such as when a preceptor sets lower or higher expectations of a student based on their race/ethnicity or expresses a racially charged political opinion), or within the social arena (such as being repeatedly asked to explain one's hairstyle).<sup>7</sup> Additionally, this list is not exhaustive, as there are many more categories of microaggressions that individuals from marginalized backgrounds may face in the classroom.<sup>12</sup> This commentary scratches the surface of what truly inclusive classrooms look like, as it does not address the spectrum of race/ethnicity, gender, sexual orientation, socioeconomic status, and physical abilities (and intersections of all of the above) of all individuals in pharmacy classrooms. Nevertheless, substituting any other marginalized identity (for example, replacing "race" with "gender identity") may permit these recommendations to remain somewhat applicable.

## CONCLUSION

The pharmacy Academy is committed to increasing the number of pharmacists from underrepresented

racial/ethnic backgrounds to address racial disparities in health care. However, in this endeavor, it is crucial that the experiences of students are investigated, and strategies to create a nurturing educational environment for all students are provided. In addition to offering strategies for the classroom, effective strategies in team-based and experiential learning environments should also be explored. One thing is clear: simply teaching providers about health care inequities has not resulted in reaching equity. Previous approaches focused on disparity statistics and cultural competence training are approaches that identify symptoms of racism but do little to challenge the implicit biases that sustain them. Color-blind instruction is not neutral, as it does not address biases but rather perpetuates them to the norm. Additionally, the upstream factors and barriers that result in disparities in the demographics of who even gets to sit in the classroom, (such as socioeconomic and education disparities, admissions requirements, lack of mentorship, limited exposure to health careers, etc) must also be addressed to meet the need for a diversified health workforce. However, by being aware of how students may experience the pharmacy classroom and reimagining the way things have always been done, pharmacy educators may make progress in combating systemic biases in health care and creating welcoming learning environments for an increasingly diverse student body.

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Appendix 1. Five experiences of racial biases and microaggressions in the classroom and suggested action items to serve as a guide for pharmacy faculty

	<b>Avoid (What not to do)</b>	<b>Implications</b>	<b>Instead (How to do it differently)</b>
1	<p><b>Lack of representation</b></p> <p>Examples:</p> <ul style="list-style-type: none"> <li>- Only using images of one type of individual in lecture slides (eg, only White individuals).</li> <li>- Learning the names of or only calling on certain students in class.</li> <li>- Describing professionalism with images/pictures of one particular type of business person.</li> <li>- Only inviting one type of individual as a guest lecturer to present</li> </ul>	<p>This contributes to the normalization of certain groups (ie, White), and characterizes minority groups as “other.”<sup>17</sup></p> <p>Additionally, this lack of representation may result in impaired ability to assess conditions in diverse populations (ie, dermatologic conditions).<sup>18</sup></p> <p>Students who are racial/ethnic minorities may not feel seen in the classroom and begin to doubt whether they belong.<sup>7,9</sup></p>	<p><b>Purposefully incorporate images, patients, and speakers of color into classrooms and presentations</b></p> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>- Intentionally search for pictures of patients of other racial/ethnic backgrounds to include in slide decks.</li> <li>- Get to know all students (including your students of color) personally.</li> <li>- Search for images and information to provide to students of other racial/ethnic or religious backgrounds regarding professional hairstyles and clothing.</li> <li>- Invite residents, pharmacists, and faculty from racial/ethnic minority backgrounds to sit on panels and to present on scientific and therapeutic topics in the core curriculum.</li> </ul> <p>Note: Take care not to tokenize – ie, calling on the same BIPOC students, colleagues etc over and over again to serve as the lone representative for their entire group to give the appearance of diversity.</p>
2	<p><b>Racial health disparities listed as standalone facts</b></p> <p>Examples:</p> <p>“African Americans are more likely to have diabetes and hyperlipidemia.”</p> <p>“Hispanic ethnicity is a risk factor for X.”</p>	<p>While these correlations could be true, presenting the statistics alone primes learners to attribute differences in burden of disease due to genetic disposition or innate racial differences.<sup>4,5</sup></p> <p>Misusing race as a proxy for genetic difference, socioeconomic status, or behavioral risk factors pathologizes race; this contributes to stigma and unequal treatment of patients who are racial/ethnic minorities, and it clouds the role of systemic racism in health disparities.<sup>4</sup></p> <p>Students may perceive that this strengthens or confirms faculty or other students’ existing negative racial biases and stereotypes against minorities.</p>	<p><b>Provide historical and social context for racial health disparities presented</b></p> <p>Recommendation:</p> <p>“Due to a history of segregation and disinvestment from communities of color, Black and Latino Americans are more likely to live in communities with lower socioeconomic status and reduced access to education, healthy foods, and health care. This reduced access combined with cultural differences in food and perceptions of disease, in addition to the stress caused by living with systemic racism, contributes to the racial differences in prevalence of chronic diseases such as diabetes.”</p> <p>Failing to provide this context is a missed opportunity to integrate the social determinants of health into the clinical curriculum and to discuss the relationships among race, structural racism, and health outcomes, whereas doing so allows students to foster an understanding of factors contributing to health equity.</p>

(Continued)

## Appendix 1. (Continued)

	Avoid (What not to do)	Implications	Instead (How to do it differently)
3	<p><b>Absent or stereotypical use of race in patient cases</b></p> <p>Examples:</p> <ul style="list-style-type: none"> <li>- Only providing a race/ethnicity for patients who are minorities (eg, not providing a race/ethnicity for White patients).</li> <li>- Presenting patient cases of stigmatizing conditions (HIV, illicit drug use, obesity, etc) with exclusively patients who are racial/ethnic minorities.</li> </ul>	<p>If race is not clinically relevant, then it does not need to be included for any patient case. Emphasizing and repeating race-disease associations may lead to harms such as delayed diagnoses and medical errors.<sup>4</sup></p> <p>Students may perceive that this strengthens or confirms faculty or other students' existing negative racial biases and stereotypes.</p>	<p><b>Be intentional and consistent with presentation of race in patient cases</b></p> <p>Recommendation:</p> <ul style="list-style-type: none"> <li>- Do not include race to achieve “diversity” or increased representation. Be thoughtful about your reason behind incorporating race in each case and consider whether doing so may cause more harm than good.</li> <li>- Ensure use of race is intentional and clinically relevant</li> <li>- When mentioning race, provide race/ethnicity for ALL patients (including White patients).</li> </ul>
4	<p><b>Using “identity-first” language with regard to socioeconomic status</b></p> <p>Examples:</p> <ul style="list-style-type: none"> <li>- Referring to someone as an “underresourced student.”</li> <li>- Referring to a patient as an “underserved patient.”</li> <li>- Using terms such as <i>urban</i> or <i>inner-city</i> as substitutes for populations of racial/ethnic minorities.</li> </ul>	<p>Socioeconomic terms are often used interchangeably to describe racial/ethnic minorities, but they are not the same. Blending socioeconomic status and race perpetuates biases by associating skin color with poverty.<sup>5</sup></p> <p>“Identity-first” language defines individuals by their differences or impairments; this puts the onus on the person and not the circumstance. By contrast, “person-first” language emphasizes the humanity of individuals. Other examples of shifts in this terminology include “persons living with HIV” and “people with diabetes” instead of “HIV patients” and “diabetics,” respectively.<sup>19</sup></p> <p>This may be perceived as “coded” language that suggests that the user is passing judgement or is using these words as euphemisms for race.</p>	<p><b>Use clear and “person-first” language</b></p> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>- Be direct. If you mean racial/ethnic minorities, say so. If referring to patients of lower socioeconomic status, say so. If you mean both, say both.</li> <li>- Consider rephrasing statements as follows: “patients who are under resourced” or “students of lower socioeconomic status.”</li> </ul>
5	<p><b>Discomfort or avoidance of discussing race</b></p> <p>Examples:</p> <ul style="list-style-type: none"> <li>- Whispering or lowering one’s voice volume when mentioning race in describing people or telling stories.</li> <li>- Letting student or patient comments that express biases or stereotypes go unchecked.</li> <li>- Claiming to be “color-blind” or getting defensive when race is brought up.</li> </ul>	<p>Students can perceive this discomfort, which in turn makes them uncomfortable in the classroom.<sup>7</sup></p> <p>This alienates individuals who are racial/ethnic minorities, making them feel invisible, and it also inherently validates the ingrained biased perspectives and social norms.<sup>14</sup></p>	<p><b>Purposefully discuss race</b></p> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>- Seek out education or training to learn to discuss race with assertiveness and cultural humility.</li> <li>- Do not ignore expressed stereotypes/biases. Acknowledge and validate the effect that racial microaggressions may have on students who are racial/ethnic minorities.</li> <li>- Hold yourself, students, and patients accountable for insulting or microaggressing comments or misrepresentations of race.</li> </ul>