THEME ISSUE: MOVING FROM INJUSTICE TO EQUITY

REVIEW

Developing A Framework to Address Health Equity and Racism Within Pharmacy Education: Rx-HEART

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Objective. The objectives of this paper are to identify current gaps in health equity and anti-racism education across the pharmacy curriculum, define the key health equity and anti-racism concepts that are suggested to be included across the pharmacy curriculum, and recommend a framework with steps to integrate health equity and anti-racism education across the pharmacy curriculum.

Findings. Other professions such as social work, nursing, and medicine have taken steps to address social injustice by integrating anti-racism into their curriculum. The National Association of Social Workers (NASW) advocates for “social justice and social change with and on behalf of clients” and included racism and health equity in its mission to eradicate “discrimination, oppression, poverty, and other forms of social injustice.” The American Association of Colleges of Nursing (AACN) curricular standards for baccalaureate nursing education provided four key changes for immediate change in the curriculum to overcome structural, individual, and ideological racism (SIIR). In October 2020, the Association of American Medical Colleges (AAMC) released a four-pillar framework to address racism.

Summary. The pharmacy profession must follow suit in the efforts to eradicate social injustices by incorporating into its curriculum topics that would result in the graduation of culturally and linguistically sensitive, and structurally competent pharmacists. This five-phase framework, Rx-HEART (Pharmacy Health Equity Anti-Racism Training) aims to provide guidance to the pharmacy academy on how to accomplish the set objectives of this paper and the themed issue on social injustice.

Keywords: anti-racism; social justice; social determinants of health; health equity; pharmacy education

INTRODUCTION

While cultural competency and health disparities are being taught to a various extent across the pharmacy curriculum, the inclusion of root causes for health disparities and how they relate back to the social determinants of health and patient outcomes is limited and inconsistent. In fact, cultural competency and health disparities have not fully been integrated into most pharmacy school curriculums and are often in the form of single didactic and case-based instruction instead of being threaded throughout the entire curriculum.1 The Pharmacist’s Patient Care Process (PPCP) addresses five steps: collect, assess, plan, implement, follow-up, and includes data collection based on a patient's lifestyle habits, preferences and beliefs, health and functional goals, and socioeconomic factors.2 Adoption of health equity education as part of the patient care process can present an opportunity for students to further engage in discussions about their impact as pharmacists within the patient care process.

Standard 3.5 of the 2015 Accreditation Council for Pharmacy Education (ACPE) and domain 3.5 of the 2013 Center for the Advancement of Pharmacy Education (CAPE) Educational Outcomes emphasize and provide guidance for the training of student pharmacists on the approach to culturally sensitive patient care.3,4 However, the current structure lacks clear strategies for addressing anti-racism and health equity. Without a clear understanding of how structural racism and health inequities contribute to health disparities, these disparities can rather be attributed to individual choices and further perpetuate existing biases, therefore continuing or worsening health disparities.5 While health behaviors are a social determinant of health and account for 30% of the determinants of health outcomes, clinical care accounts for 20%,
physical environment 10%, social and economic factors are the largest category that determines health outcomes accounting for 40%.6

Racial injustices and health inequities have been a part of our country’s existence for centuries, however, the disproportionate effects of COVID-19 and police brutality in Black, Indigenous, People of Color (BIPOC) have created heightened awareness of how health inequities and racism greatly contribute to poorer health outcomes.7,8 Structural racism and health inequities cannot be addressed by single educational seminars or discussions due to its pervasiveness. The use of terms such as racism, white supremacy, and health inequities have been traditionally avoided in the pharmacy curriculum due to discomfort and the lack of desire to face a tremendous reality. As health care professionals who take an oath to care for all, the pharmacists’ role in dismantling structural and institutional racism is imperative to practice patient-centered care in a comprehensive manner. Dismantling structural racism will require bold movement not only within the pharmacy curriculum but also by the profession at large. Evidence supports that there is a need for the profession of pharmacy to longitudinally implement new requirements of anti-racism, implicit bias, and health equity education in the pharmacy curriculum to facilitate the true practice of patient-centered care.9

The lack of minoritized faculty representation in pharmacy also must be addressed as it contributes to health disparities and the current educational gap in the pharmacy curriculum. BIPOC faculty oftentimes are the primary advocates and instructors of topics related to diversity and equity. Hagan et al note that underrepresented minority (URM) faculty usually teach students to care for underserved and minority patients by role modeling, and the absence of these faculty can have a negative effect on patient care.10 The absence of URM faculty can contribute to the curricular gaps regarding health equity and anti-racism education. According to the AACP Special Taskforce White Paper on “Diversifying Our Investment in Human Capital,” a diverse student body, faculty, administration, and staff can promote improvements in health equity.11 Additionally, the presence of URM faculty, administrators, staff, and students can counter bias and white supremacy ideologies that minorities are inferior and should not be in places of power and influence. While the personal experiences and insights of BIPOC faculty can facilitate a more welcoming climate for URM students and are valuable in addressing racial injustices and health inequities, they should not be expected to engage in this often uncompensated and underrecognized work alone. It is the responsibility of all employees of an institution to create an environment where everyone can work together to improve the experiences of our colleagues, students, and patients.

The focus of this paper is to propose a framework that addresses the intersections of social justice, health equity, and pharmaceutical care, and to facilitate the integration of these concepts throughout the pharmacy curriculum. The manuscript will outline key topics to address health equity and anti-racism, and how these topics can be integrated using champion faculty to serve as educators of these critical topics.

The objectives of this paper are:
1. To identify current gaps in health equity and anti-racism education across the pharmacy curriculum;
2. To define the key health equity and anti-racism concepts that are suggested to be included across the pharmacy curriculum; and
3. To recommend a framework with steps to integrate health equity and anti-racism education across the pharmacy curriculum.

Health Equity and Anti-Racism Education In Other Professions

Other health care disciplines have addressed health equity and anti-racism education by providing guidance on their implementation, which can be used as a guide for pharmacy. Training health professions students including student pharmacists to move from injustice to equity through education requires familiarity with key terms and concepts related to anti-racism and equity. Although the universe of these terms is vast, we offer some key terms and concepts in Table 1 to help get individuals and groups started.12-19

Medical Education

Literature shows that social, economic, and political factors produce health disparities and drive health outcomes. In October 2020, the Association of American Medical Colleges (AAMC) released a four-pillar framework to boldly address racism.20 Following the social-ecological model, the AAMC framework considers the overlapping interplay among different levels of human interaction including:20
1. Individual self-reflection and education about structural racism;
2. Embracing anti-racist, diverse, equitable, and inclusive ideology within an organization;
3. Collaborating with the academic communities for professional development opportunities and workforce diversity and inclusion;
4. Speaking out about systemic racism and expanding their efforts into communities.
In keeping with the evolving need for curricula integration of biosocial pedagogical contents in medical education, the Liaison Committee on Medical Education (LCME) frequently revises its accreditation standards. LCME Standard 7.6 provides opportunities for addressing diverse perceptions of health and illness in response to patient “symptoms, diseases, and treatments”, and recognizes the “…impact of disparities in health care on all populations and potential methods to eliminate health care disparities.”

Schiff and Rieth described a longitudinal elective course in Social Justice at John A. Burns School of Medicine that is intended to increase the medical students’ confidence in skills and attitudes towards diverse populations.

Metzl and Hansen describe “an evolving discourse that refines cultural competence in structural terms”, and defines structural competency as noted in Table 1. The authors proposed a pedagogical approach to medical education that will “foster structural competency through pre-clinical and clinical education”, and “infuse clinical training with a structural focus...coupled with medical models for structural change”. According to the authors, the five core competencies of structural competency are:

1. recognizing the structures that shape clinical interactions;
2. developing an extra-clinical language of structure;
3. rearticulating “cultural” presentations in structural terms;
4. observing and imagining structural interventions;
5. developing structural humility.

Metzl and Hansen urged clinical educators to “shift its gaze from an exclusive focus on the individual encounters to the organization of institutions and policies, and neighborhoods and cities...institutions and social conditions that produce the markers of exclusion...health effects of wealth imbalances...”. In a commentary, Hansen and Metzl assert that, “health disparities require institution-level interventions for remediation”, and clinical educators need “a pedagogical approach to foster structural competency through pre-clinical and clinical education”. The authors described the need to prepare medical practitioners to “address social and institutional barriers to health” by forming alliances to impart structural change such as engaging with multiple stakeholders including “neighborhood organizations, non-health sector institutions, and policymakers to promote patient and community health”. These “social and institutional barriers to health” are social determinants of health.

Neff and colleagues describe social inequalities as the “key drivers of poor health outcomes among marginalized members of society”. The authors discussed the uneven incorporation of structural factors into medical education and proposed the use of a novel curricular approach to address the inadequacy and fill the gap, including the addition of structural competency into the medical curriculum. The authors defined structure in terms of “social and economic policies; laws regulating the distribution of health and social resources; and social stratification based on race, ethnicity, religious affiliation, immigration status, abilities, gender identity, sexual orientation...”

Edgoose and colleagues described a train-the-trainer workshop for medical faculty on teaching racism in medical education. The authors endorsed the need for addressing the systems and behaviors that perpetuate racism to ensure the development of “skills that facilitate dialogue, preserve safety, and address conflicts...discussions and dialogue, forming committees and workgroups, curriculum development, and professional growth and commitment”. The researchers conducted a needs assessment and administered pre- and post-surveys during the workshop, and post-workshop at 2 and 6 months to the participants. While the participants expressed improved confidence in teaching racism in their respective medical institutions, they endorsed institutional challenges including lack of flexibility in the students’ schedule and time constraints in their workload for deep discussion and debriefing sessions within the anti-racism curriculum.

**Nursing Education**

Racism in the profession of nursing and nursing education has been documented and dates back to 1860 when nurse Florence Nightingale founded the first nursing school in London that only accepted European women and this racism continues to exist today.

The history of structural racism in health care and nursing education shows that racism is rarely called out, named, or openly discussed. Nursing educators have recommended four key changes for immediate implementation in the curriculum to overcome structural, individual, and ideological racism (SIIR), and to facilitate a successful, decolonized, all-inclusive nursing curriculum:

1. Learning resources must reflect multiple ethnicities to account for differences (eg, jaundice) and similarities in assessment and diagnosis;
2. Nursing researchers should not teach students to merely ‘control for race’ when health care disparities such as health access are pivotal in the burden of disease;
3. ‘Race’ must be challenged as an unproblematic risk factor for disease in course material. Clearer reflection needs to show the impact of SIIR on health status;
4. Increase visibility and influence of BIPOC faculty in academia and leadership to continually counter the effects of colonialism and racism.

These recommendations focus on what, how, and by whom the curriculum is taught and can also apply to pharmacy education and other health care disciplines. The inclusion of BIPOC nursing faculty has multiple benefits. In addition to countering the overall effects of colonialism and racism, diverse faculty can facilitate decolonizing the curriculum as well. Homogeneous majority faculty and students mainly interacting with only each other can result in the sharing of similar cultural and racial experiences, reinforcing socializations and furthering white supremacy ideologies. Without change, white privilege can remain the invisible unchallenged norm. Anti-racism education should become the unchallenged norm. Longitudinal weaving of health equity and anti-racism education into the curriculum will ensure proper integration, deepen the dialogue and prevent an hinder the progress on integrating health equity and anti-racism into the curriculum. Given these requirements, nursing courses incorporate teaching and learning about different cultures. However, Lokugamage states that learning about other cultures in the classroom will not tackle structural racism effectively, instead it can reinforce racialized stereotypes and biases that must be reflected upon and discussed. Dismantling racism in nursing education cannot be accomplished singularly or as a transient movement, it must be an ongoing requirement for every nurse.

Social Work Education

Social work (SW) has been one of the trailblazers and leaders in tackling and educating on racism and health equity. SW has been a force for social change in which BIPOC have been the primary beneficiaries. The National Association of Social Worker Code of Ethics states “the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty…Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice”. However, in a recent call to action, it was acknowledged that NASW is a predominately white association that must commit to taking action against white privilege if the profession wants to be successful in achieving social justice for people of color. This same call to action recommended that the current social work curriculum be examined to determine how its practices support institutional racism and then engage in changing those practices. A commitment to incorporating institutional racism-related content into the curriculum by educational leadership is also needed.

Tisman and Clarendon offer a thorough description of how to incorporate racism into the social work curriculum. The authors state it is dangerous for social work education to be ahistorical without properly addressing the critical interactions of social work, race, and racism. It is also dangerous for other health care curricula, such as pharmacy, to lack historical context and not address the intersection of pharmacy and racism. An essential social work skill is the ability to acknowledge and respond to issues of race and racism. A proposed model syllabus for the course, “Racism and Social Work” provides a critical exploration of how racism and race shape social work, health, institutions, culture, and beliefs and incorporates small-group activities, reflection, required readings, didactic lectures, team presentations, and discussions.

Rx-HEART: A Proposed Framework

The idea of curricular mapping or introducing concepts longitudinally throughout the curriculum is not new to pharmacy programs. In understanding how structural racism impacts social determinants of health, and consequently, patient outcomes, it is vital to make the connection that the path towards understanding personal biases and how they impact decisions we make about our patients, is a journey. This process will require colleges and schools of pharmacy to take an in-house inventory of expertise to assess what lived experiences students bring, how adept faculty are in offering their experiences and facilitating such conversations, and how the organizational structure and power dynamics aid or hinder the progress on integrating health equity and anti-racism into the curriculum. Longitudinal weaving of health equity and anti-racism education into the curriculum will ensure proper integration, deepen the dialogue and prevent an
Pharmacy education has made progress in beginning to understand how factors outside of clinical care impact our patients and community health at large. Nonetheless, as recent social movements have brought heightened importance to the conversation on social injustices including structural racism, the pharmacy profession must continue to explore ways to use this momentum to advance pharmacy education. As students, researchers, and practitioners explore their own place in this conversation, the authors hope this proposed Rx-HEART framework provides a starting point for colleges and schools of pharmacy to integrate health equity and anti-racism education across the curriculum.

CONCLUSION
Pharmacy education has made progress in beginning to understand how factors outside of clinical care impact our patients and community health at large. Nonetheless, as recent social movements have brought heightened importance to the conversation on social injustices including structural racism, the pharmacy profession must continue to explore ways to use this momentum to advance pharmacy education. As students, researchers, and practitioners explore their own place in this conversation, the authors hope this proposed Rx-HEART framework provides a starting point for colleges and schools of pharmacy to integrate health equity and anti-racism education across the curriculum.

ACKNOWLEDGEMENTS
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REFERENCES


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<tr>
<th>Terms</th>
<th>Definitions</th>
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<tr>
<td>Racism</td>
<td>Racism is the act of oppression based on race whereby a group of individuals use their social and institutional power to discriminate against another group through institutional policies and practices that ultimately shape the cultural beliefs and values of the dominating group.</td>
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<td>Systemic racism</td>
<td>This includes “…structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by “race”.”</td>
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<td>Structural racism</td>
<td>This involves “the micro-level systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups.”</td>
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<td>Cultural racism</td>
<td>“…representations, messages, stories conveying the idea that behaviors and values associated with white people or “whiteness” are automatically “better” than those associated with other “racially” defined groups; shows up in advertising, movies, history books, policies, laws.”</td>
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<td>Institutional racism</td>
<td>This defines ways in which institutional policies and practices create disparate outcomes depending on race, leading to the creation of advantages for Whites and oppression and disadvantages for people Black, Indigenous, People of Color (BIPOC).</td>
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<td>Discrimination</td>
<td>This is the unequal treatment of a group of individuals based on “race, gender, social class, sexual orientation, physical ability, religion and other categories or characteristics.”</td>
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<td>Implicit bias</td>
<td>This is an act of unknowingly or unconsciously holding negative associations that are expressed automatically, without conscious awareness.</td>
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<td>Equity</td>
<td>This is the act of fairness and impartiality in the access and distribution of goods, resources, and services.</td>
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<td>Racial equity</td>
<td>“Racial equity is the condition in which one’s racial identity no longer predicts how one fares in any given situation; is often considered a part of racial justice.”</td>
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<td>Health equity</td>
<td>“…the fair, balanced rates and costs of health care coverage, access to care, quality of health care…removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”</td>
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<td>Racial justice</td>
<td>This is the act of systematic fair treatment and distribution of resources across races to ensure equitable opportunities and outcomes, and full and equal racial representation in the society.</td>
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<td>Racial injustice</td>
<td>This is the opposite of racial justice where there are social inequality and disadvantages, and disparities based on races, which could be a result of historic oppression, inequality of inheritance, or overall racism and prejudice, especially against minority groups.</td>
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<td>Social justice</td>
<td>This is fairness and balance in the distribution of resources, opportunities, and privileges and affording equal economic, political, and social rights and opportunities to everyone, thereby creating a psychologically and physically safe and secure environment.</td>
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<td>Term</td>
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<td>Anti-racism</td>
<td>This is the act of actively opposing racism through advocating for changes in political, economic, and social ideologies and practices.</td>
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<td>Diversity</td>
<td>These are the variety of social identities including differences in ideas, perspectives, values, race, ethnicity, gender, and any other construct used to categorize people within a space, community, institution, or society.</td>
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<td>Inclusion</td>
<td>This is the act of “authentically bringing traditionally excluded individuals and/or groups into the processes, activities and decision/policy making in a way that shares power; welcoming, not merely tolerating.”</td>
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<td>Health Disparities</td>
<td>These are “...preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.”</td>
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<td>Social determinants of health</td>
<td>These are “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”</td>
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<td>Cultural competency</td>
<td>“The capacity to value diversity, manage the dynamics of difference, acquire cultural knowledge and adapt to diversity and the cultural contexts of the communities one serves.”</td>
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<td>Structural competency</td>
<td>This is “the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication “non-compliance,” trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health.”</td>
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Table 2. Sample Cursory SWOT Analysis of Anti-Racism Work Across the Curriculum

<table>
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<th>Strengths</th>
<th>Weaknesses</th>
<th>Opportunities</th>
<th>Threats</th>
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<td>Faculty/Staff with expertise in anti-racism work</td>
<td>Missing representation across faculty and students</td>
<td>Existing courses/lectures where the use of race can be corrected (i.e. as a</td>
<td>Perceived resistance among faculty/staff and students around anti-racism work</td>
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<td>Faculty/Staff and students with diverse lived experiences</td>
<td>Lectures/courses where race is used inappropriately as a biological</td>
<td>Other disciplines located within or nearby, or affiliated with a school/college of pharmacy that already engages in some anti-racism work/teaching (i.e. nursing, medicine, social work, etc.)</td>
<td>Lack of advocacy for budgetary allowance/expansion for anti-racism education efforts</td>
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<td>Faculty/Staff and students with lived experiences shared by the patients/communities served by the program</td>
<td>Lack of leadership buy-in/advocacy of anti-racism efforts within the program</td>
<td>Affiliations with community organizations, civic engagement groups where partnerships can be strengthened (i.e. syringe exchange programs, safe injection sites, health equity groups, community centers focused on improving literacy efforts, local housing authorities, food banks, etc.)</td>
<td>Community mistrust</td>
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<td>Any existing lectures/courses that cover anything across the spectrum of anti-racism work (e.g. social determinants of health, cultural humility, structural racism, health equity)</td>
<td></td>
<td>Identified expertise within and external to the profession (speakers, videos, conferences, etc.) that may augment strategic efforts to integrate anti-racism education in a sustainable manner</td>
<td>Historical precedence and events that may contribute to institutional resistance and/or meaningful community engagement</td>
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Figure 1. Rx-HEART framework – Pharmacy Health Equity Anti-Racism Training

- PHASE Inventory
  - Perspectives
  - Expertise
  - SWOT Analysis

- PHASE Elective
  - Consistent offerings
  - Available to some

- PHASE Mandatory
  - Required by all students
  - Some exposure

- PHASE Integration
  - Routine exposure
  - Contextualized throughout the curriculum
  - Opportunities for reflection

- PHASE Application
  - Ability to identify gaps
  - Consistent interactions and opportunities to engage
Figure 2. Sample Questions to Guide Integration of Five-Phase Framework, Rx-HEART

Phase 1: Inventory/Awareness

- What perspectives do your students/faculty/staff offer?
- What perspectives are missing?
- Does your faculty and staff have representation that mirrors your student body?
- Does your faculty and staff have representation that mirrors the patients and community you serve?
- For the faculty who have expertise in this area, are they supported to maximize their impact on students, their colleagues, and/or the institution?
- How is race data used across the curriculum?
- Conduct a mini SWOT analysis of anti-racism work in the program.

Phase 2: Elective offerings

- Where in the curriculum is anything consistently being offered in the area of health equity and anti-racism?
- This may include single lectures, series of lectures, consistent extracurricular or co-curricular programming, and standalone elective, didactic, or experiential courses.
- These offerings should include those that are NOT ones that ALL students are mandated to engage with.

Phase 3: Mandatory offerings

- Where in the curriculum is there a mandatory offering in the area of health equity and anti-racism?
- This may include mandatory lectures, seminars, courses, activities that ALL students are mandated to engage with at some point in their curriculum.

Phase 4: Integration

- How often in the curriculum are the students being exposed to any activities/and lectures around health equity and anti-racism?

Phase 5: Application

- How are students applying their knowledge in these areas?
- How are students engaging with other perspectives/experiences to assess and fill their own gaps with consistent interactions in the areas of health equity and anti-racism?