Editorial

Diversity, Equity, and Inclusion in the Profession of Pharmacy: The Perspective of Three Pharmacy Leaders

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Abstract

Description

Diversity, equity, and inclusion (DEI) is a growing force within all industries, with healthcare being no exception. The 2020 sociopolitical landscape made DEI a priority for the majority of organizations. The structural element of DEI education in pharmacy is comprised of academia, professional organizations, and healthcare systems and companies. To address inequities that stand before students, professional pharmacy organizations must have a voice that sets an inclusive tone. This article provides background into DEI in the pharmacy profession and provides the unique perspectives of 3 pharmacy leaders.

Keywords

diversity education; equity; inclusion; DEI education; pharmacy education; reflection

Introduction

Diversity, equity, and inclusion (DEI) is a growing force within all industries, with healthcare being no exception. Largely, the term speaks to ensuring there is representation and fairness, and that people feel respected and valued. The Society of Human Resource Management (SHRM) defines the components of DEI as:[1]

Diversity – Similarities and differences among individuals that comprise personality and identity

Equity – Fair treatment in access, opportunity, and advancement

Inclusion – The extent to which individuals feel welcomed, respected, supported, and valued

During the year 2020, a confluence of sociopolitical events prompted many organizations to examine DEI concepts, with many creating comprehensive work streams around it. Across the healthcare landscape, DEI can have a significant impact including how care is delivered to patients and how patients, in turn, perceive their care.[2] There is growing evidence to suggest that racially concordant care between providers and patients may be associated with improvements in communication, leading to positive patient outcomes.[3,4] This speaks to the need for a more diverse, equitable, and inclusive framework that will be reflected in how pharmacists issue care. It also speaks to the need for centers of pharmacy education to consider whether the demographics of their pharmacy students reflect the populations that they may serve in the future.[3,5] That framework is a structure of education and representation. As compared to the United States (US) population, Black, Hispanic/Latino, and people of 2 or more races are underrepresented in the profession of pharmacy.[6] In this article, we will examine how education and representation matter through the lens of 3 pharmacist leaders.

To continue to define diversity, characteristics such as race and gender are conspicuous but fail to capture deeper aspects or nuances of an individual. **Table 1** provides a snapshot of

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some of the dimensions of diversity. Individuals are not shaped by 1 singular characteristic that creates their uniqueness or identity but have multiple facets that comprise who they are (intersectionality). For example, a college-educated (education), unmarried (marital status), Dominican (national origin) woman (gender) illustrates some of this individual's many dimensions of diversity. When looking at combinations of dimensions of diversity, intersectionality is created. This individual may have similar experiences in the workplace as another college-educated woman of color. A 2023 study by Vohra-Gupta, et al, intersectionality demonstrated that single women of all racial/ethnic groups had more barriers to care than partnered white women.[4] This study potentially highlights that people with multiple dimensions of diversity are at risk of experiencing worse healthcare outcomes.

A challenge to addressing diversity lies in bias, specifically unconscious or implicit bias. Unconscious bias captures the favorable and unfavorable stereotypical assessment of others based on dimensions of diversity. Common occurrences of unconscious bias happen when patients are presumed to be less intelligent or less likely to adhere to care instructions based on race or socioeconomic status. Another unfortunate example is when Black and Hispanic patients do not receive pain management due to perceptions of these populations having a higher pain tolerance or are more likely to abuse medications.[6,7] That assessment leads to feelings and attitudes that can become verbal and/or behavioral insults, which may ultimately result in an undesirable environment. These insults are often microaggressions or unintended acts of discrimination. In fact, microaggressions commonly occur in academic and professional settings. For example, a simple statement such as, "You're so articulate" or "You're so well-spoken" when spoken to a person from a marginalized community could be interpreted as an assumption that the person should be less articulate (unconscious bias) because they are from a marginalized community. Such statements are microaggressions.[8] Unlike macroaggressions, the large-scale, overt aggressions that mostly occur at the system level, microaggressions are interpersonal.

The structural element of DEI education in pharmacy is comprised of academia, professional organizations, health systems, and other healthcare companies. In academia, challenges include inequities in the financial status of students and minority-serving institutions (MSIs), as well as unconscious bias based on dimensions of diversity.[8] According to data from a 2019 American Community Survey, Black people, Hispanic people, and Native American people comprise 31% of the US population (Black, 12.7%; Hispanic, 18%; Native American 0.8%), but only 15.7% of the total number of PharmD degrees conferred in 2019 (Black, 8.8%; Hispanic, 6.4%; Native American, 0.3%). Thus, these racial and ethnic groups are underrepresented in the profession of pharmacy as compared to

Table 1. Dimensions of Diversity[1]

Dimensions of Diversity	
Primary	• Age • Race • Ethnicity • National origin • Gender/Gender identity • Sexual orientation • Mental/Physical ability
Secondary	• Religion • Education • Geographic location • Language/Accent • Social class • Appearance • Military status • Marital status

the US population. As we look to the future of pharmacy practice, specific strategies must be incorporated into the recruitment of residents and personnel to increase the diversity of candidate pools.[9] An example of such a strategy is increasing access to pharmacy school through scholarship dollars and funding provided to historically black colleges and universities (HBCUs). HBCUs make up 4% of pharmacy schools and colleges across the country but accounted for 22.8% of black student enrollment and 13.8% of total people of color enrollment between 2015 and 2019.[5] Focus on representation is for the sake of patient care, as patients have better outcomes when their dimensions of diversity are represented by their providers.[5,10,11]

Strategies targeted toward resolving inequities are crucial because if not addressed, the profession is poised to promote microaggressions and discrimination. Patients receive care that is more equitable from a more diverse healthcare workforce. It has been found that many healthcare providers have unconscious biases and that patients from marginalized communities are less satisfied with their healthcare provider interactions.[10-12] The COVID-19 pandemic highlighted several instances in which diversity within the pharmacist profession was crucial to increasing the uptake of vaccines within marginalized populations. One of these populations is the Black community. A group of pharmacists described a framework for Black pharmacists to address gaps in health equity in the Black community during the pandemic. The framework calls for building community partnerships, engaging national pharmacy and medical organizations, improving vaccination access, and reducing vaccine hesitancy.[13] The approach of this framework to promote health equity can be applied to other areas also (eg, medication adherence) as it distills down to partnerships, advocacy, access, and education, hopefully reducing vaccine hesitancy.

To address inequities that stand before students, professional pharmacy organizations must have a voice that sets an inclusive tone. From the academic perspective, the American Association of Colleges of Pharmacy (AACP) has made diversity, equity, inclusion, and accessibility (DEIA) a priority, including the acknowledgment that pharmacy graduate knowledge gaps can contribute to health disparities and inequities. AACP goes further with a call to action to academia and professional pharmacy organizations to elevate DEIA topics.[14] The Accreditation Council for Pharmacy Education (ACPE) has taken action and designated cultural sensitivity as an educational outcome.

The American Society of Health-System Pharmacists (ASHP) established the ASHP Task Force on Racial Diversity, Equity, and Inclusion that has provided recommendations for its organizational workings, colleges of pharmacy, residency programs, hospitals, and health systems. ASHP has also created a DEI Certificate. This certification is an educational guide that allows pharmacists and pharmacy technicians to apply DEI strategies professionally and personally, such as, how to recruit and retain diverse talent, create an inclusive environment, and implement a DEI strategic plan. Other societies that represent specialty fields within the practice of pharmacy have also made commitments to DEI by establishing either task forces or committees to address these issues. Two notable examples include work by the Society of Infectious Disease Pharmacists (SIDP) and the Hematology/Oncology Pharmacy Association (HOPA). These steps and actions are critical to assist with the establishment of DEI as an industry standard.

Following the continuum from student to healthcare provider, the next focus becomes the workplace. Organizational DEI must be a strategic business imperative in hospitals, health systems, and healthcare companies. Businesses are up to 29% less profitable and have lower retention rates, employee engagement, and recruitment return, as well as less innovation and a weaker community image when DEI is not a part of the daily operations and culture. These results are applicable across all industries, increasing job performance by up to 56% and decreasing sick days by 75%.[15,16] Pharmacists must be ready to apply 'real world' learnings from their professional education as inclusive leaders in order to provide optimum care and lead thriving business units. Hospitals, health systems, and healthcare companies must make organizational DEI a strategic business imperative.

With some background and qualifiers established for DEI within the profession of phar-

macy, the following section represents the authors' observations of DEI within their own lives, education, and professional pharmacy careers.

Perspectives

Aigner George, PharmD

My journey has been both unique and standard as a woman of color within the profession of pharmacy. While I grew up in a relatively diverse environment and went to diverse schools, I made the decision to complete my pre-pharmacy and pharmacy school education at a historically black college and university (HBCU). My collegiate years, therefore, were academic and cultural, giving me the opportunity to thrive in a way that my Black peers have shared they were not able to at predominately White institutions (PWIs). Smaller class sizes are a certain benefit; however, the grooming and nurturing allowed me to excel in a cultural context that I could not have achieved outside of an HBCU. I had some validation of my experience by taking summer courses at a PWI. I dropped those classes as I felt the environment to be sterile; I was a student on the roster and that was how the professor behaved. It seemed my questions were burdensome for him to answer; as if they were not worth my asking. I missed having a dynamic with my professor where I knew that my success was their success. I preferred my learning to be somewhere I had a stronger sense of belonging and knew I mattered as a student.

Residency took me to South Florida where diversity was significant, and I felt a strong sense of inclusion. The kick-off to my hospital administration career started to present some differences. From a community perspective, and when looking at colleagues not in leadership roles, diversity was present, however, disparity became clear as I started to advance; I had become under-represented based on race and age (I still am). What this has meant for me is that I am asked questions about my racially/ethnically ambiguous appearance (as seen by some), I am asked if someone can touch my hair whether wearing it curly or straight (in some cases, they are bold enough to do so without asking), and I feel out of place with minimal to no representation. To put representation into context, it is about being confident that someone of my design is regarded for consideration and placement in leadership roles, regardless of racial/ethnic appearance. That is what made my collegiate years so compelling—not since then have I been in an environment where the majority were people of color and all had transparently equitable access and opportunity. While a work environment resembling the breadth of people of color I experienced may not be achievable, transparently equitable access and opportunity should be.

Keith Teelucksingh, PharmD, BCPS, BCIDP

As I reflect back on the path that got me to where I am today, I am fortunate to have experienced diversity within my personal life, education, and post-graduate pharmacy training. I attended pharmacy school at a large state university. While the demographics of my class were similar to the statistics noted at the beginning of this article, I was fortunate to be on the ground level of some significant events highlighting diversity. My class established the inaugural cultural dinner where foods from various cultures were showcased in addition to talent shows from the student body. For the record, I made fried wontons, which were a hit. For economically strapped students, the cultural dinner was a great place to be exposed to dimensions of diversity while having a relatively low-cost meal. For my experiential fourth-year Advanced Pharmacy Practice Experience (APPE), I returned to Miami, FL, and did all my rotations at the largest county hospital. My post-graduate training took me to San Francisco, CA, and I practiced in hospitals there for nearly a decade before taking an administrative role with HCA Healthcare.

In my opinion, a hospital is the most significant societal crossroad we currently have. Everyone needs healthcare at some point and, as a result, one is exposed to a diverse array of cultures and people. This also applied to my co-workers. I have worked with folks whose origins could be traced back to Eritrea, Iran, Nigeria, Poland, Mexico, United Kingdom, Vietnam, Japan, and Thailand, just to name a few, and I learned immensely from them. In sum, I cannot think of a more diverse setting than healthcare in general. Thus, it is so very important that diversity is echoed in leadership roles in hospitals, espe-

cially in pharmacy, and all the way up the chain. Similar to how we are encouraging pharmacy programs to recruit students who reflect the diversity of the patients they serve, we need to encourage healthcare companies to recruit leaders who reflect the diversity of the staff that they lead. It took some jarring events for many of us to collectively reflect on the lack of diversity in leadership roles but I am proud to work for a company that is striving to be better in this regard, and I am here to help further those conversations.

Kara Fortune, PharmD

Living in a suburban bubble in the Southeastern US, I grew up in a strict, very uniform environment not grasping the importance of diversity and inclusion from a young age. At each phase of my education, I have had the opportunities, support, and role models that were necessary for me to succeed. Moving away from home to attend college gave me the opportunity to step away from what I had always known and to see the world through someone else's eyes. As I have matured throughout my personal life and career, my awareness and appreciation of diversity and cross-cultural understanding have grown.

As I move through the workforce, I have learned that many healthcare work environments fail to address systemic inequalities and biases in hiring and mentoring relationships, and the underrepresentation of women and underrepresented minorities in prominent leadership positions. I believe it is important to create a work environment where all employees can feel supported, uplifted, and safe. In work and life in general, we should all strive to respect one another and focus on what we can learn from each other. A diverse and inclusive workplace benefits our clients/customers, our culture, and our impact, and it makes work more productive and more enjoyable. As I move forward in my career, I intend to continue to learn more through an awareness of intersectionality, to better acknowledge and support the differences among us.

To put the words of this article into a simple provision through another lens and quote Verna Myers, Diversity and Inclusion Expert, "Diversity is being invited to the party; Inclusion is being asked to dance."

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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