CREATING OPEN SPACES: CULTURAL HUMILITY IN PRACTICE

AS COVID-19 CONTINUES to devastate the United States, one thing has become painfully clear: Communities of color, especially Black and Hispanic Americans, are bearing the brunt of the crisis.

Racial tensions in the nation are also riding high as Americans contend with the recent tragic deaths of George Floyd, Breonna Taylor, Ahmaud Arbery, and too many others.

Asian Americans are facing heightened discrimination and xenophobia as a direct result of the pandemic.

Now more than ever, people across the nation are being forced to confront thoughts, faces, and realities different from their own. And as the most accessible health care provider and pillars of their communities, pharmacists are not exempt.

With the pandemic shedding a light on the country's glaring racial and ethnic disparities, CDC has called for health professionals to provide culturally competent care and to identify and address unconscious biases that may hinder that care.

But cultural competence is necessary every day, pandemic or not, and it takes practice.

"Across the country and around the world, communities are getting more and more diverse, and not just in terms of immigration or ethnicity, but what people's expectations, backgrounds, and experiences are," said Zubin Austin, BScPhm, PhD, of the Leslie Dan Faculty of Pharmacy at the University of Toronto, Ontario, Canada. "Understanding and having the self-confidence to be able to navigate that diversity is so essential if we are to provide care, if we are to meet patients' needs, and if we are to fulfill our mandate as a profession."

'A LIFELONG COMMITMENT'

Studies have shown that culturally competent care improves patients' health, reduces disparities, and promotes health equity.

"We see reduced health care cost. We see greater adherence to medications. It is also linked to greater patient satisfaction," said Lakesha Butler, PharmD, BCPS, clinical professor and diversity and inclusion coordinator at Southern Illinois University Edwardsville's School of Pharmacy, and national pres-

ident of the National Pharmaceutical Association.

But what does cultural competence mean?

"Cultural competence refers to a person's comfort with and ability to interact with a diverse group of individuals who have different backgrounds, different expectations, and different life experiences," said Austin.

It begins with cultural awareness, or the "self-examination and in-depth exploration of one's own cultural background," and leads to cultural humility, said Butler.

"Cultural humility is a lifelong commitment to learning and critical self-reflection, so we never arrive at a point where we're done learning," continued Butler, whose research centers on cultural competence in health care and health disparities among minority and underserved populations.

Cultural competence and humility revolve around three components: knowledge, skills, and attitude, said Austin. The first aspect, knowledge, is about understanding history, our own preconceptions and biases, and people's diversity in background, perspective, and experience.

The second aspect refers to the skills of observation, listening, and empathy. "Are we truly listening and hearing what people are asking of us? Are we responding appropriately," said Austin.

The third component, attitude, promotes openness. "It's not good enough to simply accept or tolerate people who are different. What we need to do is actually help them express their diversity and support them in being who they truly are in their communities," said Austin.

Cultural competence and humility are crucial to pharmacy practice, said Ahmed Abdelmageed, PharmD, former assistant dean of student, alumni, and community engagement at Manchester University College of Pharmacy, Natural and Health Sciences in Fort Wayne, IN.

"A lot of times, we perceive these things as secondary skills, but this is essential to our conversations and to our practice," he said. "If we establish that relationship of trust, if you know that I know you beyond just a script, and that I do care for you and your well-being—which comes from understanding your culture, background, family structure, and things like that—then I am a lot more able to positively influence your health outcomes."

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SELF-EXPLORATION AND UNCOVERING BIAS

Self-exploration and reflection are the backbone of cultural humility.

"Cultural humility is a journey. That's one of the first things I tell my students," said Butler. "It is not an end goal. You will be consistently growing, and you have to first take the steps of understanding yourself."

As part of the process, Butler walks her students through Harro's Cycle of Socialization. "It helps them understand what they were taught on a personal level by their parents, teachers, and others that they trusted from childhood; and then what messages were reinforced from the media, school, and home practices—that is cultural socialization."

As the students reflect, they come to understand the impact their socialization has had on the way they see and navigate the world and whether it has caused them to "utilize privilege or discrimination toward others," Butler said.

The exercise, at times uncomfortable, encourages individuals to take inventory of their unconscious biases—the type of biases that often creep up in health care, said Butler. "Most people in health care have a heart to help people. So typically, we don't see a lot of conscious or explicit biases come out," she said.

Butler also uses Harvard University's Implicit Association Test in her teaching. This tool has been "tested, validated, and used for many years to determine what social identities or groups you have a bias against," she said.

As students do this work of self-exploration, Butler said that they begin to be more aware of their interactions with others. "They became more conscious that they were turning their nose up at individuals based on the way they looked, the car they drove, or them not having insurance or having Medicaid—they would separate themselves unintentionally," she said. "That's when change really started to happen."

UNDERSTANDING HISTORY AND SOCIAL DETERMINANTS OF HEALTH

An integral piece of cultural competence and humility is understanding history and how it feeds our biases, our communities, our institutions and systems, and those all-important social determinants of health, said Butler.

Many pharmacists are familiar with the social determinants—economic stability, education, access to health care, neighborhood and environment, and social and community context. These factors have tremendous influence on individual and community health and are often the root of many health disparities.

Consider the COVID-19 crisis, for example.

Data from most U.S. states and

numerous studies report that the pandemic is disproportionately ravaging communities of color, particularly Black and Hispanic Americans (see sidebar).

Unfortunately, none of this is new, said Abdelmageed.

Racial and ethnic health disparities have long existed in the United States. "What COVID-19 has done is just put a spotlight on the chasm that already existed," he said.

According to CDC, social determinants of health are behind these disparities. For instance, racial and ethnic minorities are more likely to live in densely populated areas and multigenerational households, which make preventive practices, such as social distancing and isolating from older adult and immunocompromised family members, more challenging.

Racial and ethnic minorities, particularly Black and Hispanic individuals, are also overrepresented in essential industries and do not have the privilege of working from home. CDC reported that nearly 25% of employed Hispanic and Black workers are in service industry jobs compared with 16% of non-Hispanic whites. Many do not get paid sick leave and are forced to continue coming in to work even when they are sick in fear of financial implications.

Many in these communities also have lower access to health care, said the agency. Compared with whites, Hispanic individuals are nearly three times more likely to be uninsured, and Black individuals nearly twice as likely. Even with access, other barriers may exist, such as language proficiency or being unable to miss work for a health visit.

CDC attributes these disparities to systemic inequities and institutional racism.

A history of housing discrimination, segregation, and redlining—the systemic practice of denying government resources to predominantly Black neighborhoods because they were deemed a financial risk—have created a host of mental and physical health barriers for people in these communities. Such barriers include the creation of food deserts in which poor nutritious choices, such as fast food restaurants, are the only options or the most affordable.

Pandemic sheds light on U.S. racial health disparities

According to an NPR analysis published on May 30, 2020, of data collected by the COVID Racial Data Tracker, a joint project of the Antiracist Research & Policy Center and the COVID Tracking Project, Black Americans are dying from COVID-19 at a rate nearly twice as high as their share of the population. In four states, that rate is three or more times higher.

While the data is limited—at the time of writing, only 48 states have reported confirmed cases, and only 44 have reported deaths—the numbers reveal stark racial and ethnic disparities in the United States.

In addition, a study published by Millett and colleagues on May 14, 2020, in *Annals of Epidemiology* revealed that while disproportionately Black counties account for only 22% of U.S. counties, they were the location of 52% of COVID-19 cases and 58% of deaths.

The data tracker revealed that Hispanic and Latino Americans are also being hit hard, testing positive for COVID-19 at rates higher than expected for their share of the population; in 30 states, the rates are two times higher, and in eight states, they're more than four times higher.

Limited data from smaller racial minority populations also reveal glaring disparities. For example, Native American communities in New Mexico make up 60% of cases but only 9% of the state population. And in Arizona, Native Americans account for 21% of deaths despite making up only 4% of the population.

White deaths, on the other hand, are lower than their share of the population in 37 states and the District of Columbia.

While Asian Americans are faring better than other racial minority groups (but still below white Americans), they are also seeing disproportionate cases in several states. For example, in South Dakota, Asian Americans account for only 2% of the population but 12% of cases.

Scarcity of COVID-19 data in Asian Americans could be attributed to lower rates of testing among this group. COVID data for Asians tend to be lumped together with Hawaiian and Pacific Islanders, further muddying up the waters.

Aggregation of Asian American data may also mask disparities among different Asian groups. A study published online in *American Journal of Public Health* on March 11, 2020, by Adia and colleagues revealed that while Asian Americans as a whole appeared healthier than non-Hispanic whites, disaggregating the data revealed a number of disparities.

Compared with non-Hispanic whites and Asians overall, Vietnamese respondents reported fair or poor health more than twice as often; Japanese and Koreans reported higher rates of diabetes; and Filipinos experienced higher rates of high blood pressure, asthma, heart disease, and delayed medication usage.

Physical safety may also be a concern for some individuals. "We typically want our patients to get out and exercise, but they may live in an area without sidewalks or where it is not safe," said Butler.

"There's also the social determinant of chronic stress," Butler continued. Patients in minority communities may face external stressors, such as racial discrimination, financial instability, and food and housing insecurity.

All of these factors combined contribute to higher rates of chronic diseases, such as diabetes, cardiovascular disease, or asthma—the same underlying conditions linked to severe COVID-19, Butler pointed out.

Many minorities also have a longstanding distrust of the health care system, said CDC.

For many Black Americans, this distrust is partially linked to the Tuskegee Syphilis Experiment in 1932, in which the U.S. Public Health Service used Black men, without their knowledge, to conduct a secret study on the progression of syphilis. The study lasted for 40 years, even after a cure for syphilis was found in 1947, and resulted in severe health problems and the death of many of the participants, and in some cases, the infection of their wives and children.

This distrust may also exist for immigrants during COVID-19, according to a May 8, 2020, article published in *JAMA Internal Medicine* by Ross and colleagues. Patients with fears about immigration enforcement may delay going to the hospital or accessing other medical services, said the authors. Furthermore, undocumented individuals may not have access to insurance or care.

This is why understanding social determinants with a historical context is crucial for pharmacists practicing cultural humility, said Butler. "Learn the history of our country. Learn the history of the injustices and overt discrimination against most of these [marginalized] groups—people of color, LGBTQ, and other underserved communities," said Butler.

OPENING THE DOOR

In practice, cultural humility is simply about conversation, said Abdelmageed. Ask questions from a place of care, and don't assume.

"Is there anything from a cultural perspective you want me to be aware of? Are you taking any herbal medications? Do you want me to be aware of any religious practices?—Open that door for [the patient] to share information without imposing any preconceived notions," he said.

> "Change is not going to happen overnight, but you still need to keep pushing. Others are pushing right along with you."

Creating these open spaces can go a long way, especially as patients of color often report feeling unheard or dismissed by health professionals.

"Being respected, being valued, and being heard is essential for all human beings, and health care systems have a terrible track record of ignoring disadvantaged peoples, of overlooking their needs," said Austin. "The experience of actually being listened to and heard can be so powerful for someone who's never been listened to and heard, and this is something that community pharmacists, in particular, can do.

"Be an advocate for groups who have difficulty advocating for themselves," Austin continued.

Certain groups, such as recent immigrants, are at higher risk, he said. Many may be economically and socially disadvantaged and may have difficulties communicating in the English language.

"All of these things that potentially mark recent immigrants as outsiders to a community also provide a reason for some people to not respect them, not listen to them, and not want to help them. And over time, this becomes a downward spiral," said Austin.

"I see it consistently in the patients I interact with, especially those from underserved or underrepresented minorities," Butler said. "They have a sense of 'I'm being judged' by [providers] that don't look like them, and so they may not feel as comfortable with sharing important information [about their health]."

This prevents pharmacists from providing the best care they can.

PHARMACISTS AS RESOURCES AND ADVOCATES

Pharmacists should take some time to familiarize themselves with programs, services, funding agencies, and social support agencies in their local communities that are there to help underserved patients, said Austin. Many of these resources are already in place, but patients may have trouble navigating the health system and accessing them.

"We are the easiest, most accessible form of health care, especially in the community setting," said Abdelmageed. "I think the onus, in a way, is upon us to have resources available for our patients."

Austin agrees. "Pharmacists are in a great position to act as health navigators," he said. "This is the phone number. This is the website. You don't have access to Wi-Fi? Well, let me fill out this form for you. You don't know how to speak English well enough to talk to this person on the phone? Let me take

a few minutes to actually phone on your behalf."

A simple action is to prepare a resource list of phone numbers, websites, agencies, or community supports, said Abdelmageed. "Every pharmacy [has] a drawer with a folder full of the menus of places to eat around us, who delivers the fastest, who has a deal on this day," he said. "Why can't we have a folder like that but of the resources available around us—contact information of the free clinic close by, or the church that has medications in its basement, or the mosque that does a health fair?"

And pharmacists who have the capacity can do more, said Butler.

"We saw that the testing sites for COVID-19 may not be readily available [or accessible] in underserved areas," she said. "If you are a pharmacist working for a pharmacy organization, you can take a stand and voice your desire to help mitigate those health disparities by doing COVID-19 tests [in those areas]."

"Being intentional is an important theme here—not expecting for individuals from underserved communities to come to you or for them to help themselves, but really taking a stand and saying 'I want to see through your eyes ... [and] do my part as much as I can to actually seek opportunities and ways to increase access to these communities,' " she said.

Advocate for inclusive policies, practices, and processes in your institution and community, said Butler. Speak up against injustices, and hold your peers and institutions accountable every day for statements or actions that are not inclusive, she continued.

"Be vocal, and check your peers' biases, as well. Provide resources. I'm a big proponent of anti-racism, [the active policy or practice of opposing racism and promoting racial tolerance], and I think that's an important piece of cultural competence," she said. "You can have the best heart or have the best intentions, but if you have negative bias against someone of a different race, gender, or any other social identity, it's inherent that you're most likely not going to provide the best care to those patients."

Call for more cultural competence training, too, said Butler. "It's certainly a requirement in the accreditation standards for pharmacy schools, … but I think we're short-changing [students] by just providing a small amount of instruction in this area."

And most importantly, stay hopeful, said Abdelmageed.

"I think the biggest enemy is despair, and no matter how hard or bad it gets, realize that you can still, at the end of the day, influence change, whether it's by using your advocacy voice or your advocacy money to bring these issues to light," he said. "Change is not going to happen overnight, but you still need to keep pushing. Others are pushing right along with you."

Aina Abell, assistant editor

Pharmacists can be LGBTQ+ allies

The LGBTQ+ community, consisting of lesbian, gay, bisexual, transgender, and queer/questioning individuals, as well as other sexual and gender minorities, have unique health needs and barriers. As the most accessible provider, pharmacists can address these needs and be allies to LGBTQ+ patients.

According to the National LGBT Health Education Center, a program of the Fenway Institute, the LGBTQ+ community experiences several health disparities, including higher rates of smoking, substance use disorder, unhealthy weight control or perception, and violence victimization than heterosexual individuals. Some populations, particularly men who have sex with men and transgender women, have higher rates of HIV and other STIs.

LGBTQ+ individuals also experience higher rates of depression and anxiety than their heterosexual counterparts. According to CDC, lesbian, gay, and bisexual youth are five times more likely to attempt suicide. Transgender individuals are at highest risk, with a reported 19% to 25% attempting suicide before undergoing gender confirmation surgery.

CDC says that while differences in sexual behavior account for some of these disparities, others are linked to social and structural inequities, such as discrimination, stigma, access to health care, and more. Racial disparities further compound these challenges for non-white individuals.

In a January 31, 2020, commentary in the *American Journal of Pharmaceutical Education*, Grundmann and colleagues wrote that LGBTQ+ patients, especially those who are transgender and/or queer, report more negative experiences "disclosing their sexual and gender identity to their health providers and subsequently being denied service." This discourages patients from seeking care and sharing important health information with providers.

Pharmacists are in a unique position to connect with and counsel LGBTQ+ patients, wrote the authors, and this requires a culturally competent approach. One way to do so is fostering an inclusive and welcoming environment, says the National LGBT Health Education Center. This could mean "simple changes in forms, signage, and office practices," such as including sexual orientation and gender identity in intake forms or displaying educational brochures on LGBTQ+ health topics.

Pharmacists and pharmacy personnel should also receive education and training on LGBTQ+ health and how to respectfully interact with LGBTQ+ patients. This includes asking open-ended questions without assuming heterosexuality and using a patient's preferred names and pronouns.

For the National LGBT Health Education Center's guide to LGBTQ+ health, visit https://apha.us/LGBTHealth.

For a glossary of LGBTQ+ terminology, visit https://apha.us/LGBTGlossary.

For CDC's LGBT resource page, visit https://apha.us/CDC_LGBT.