

COMMENTARY

Black Lives *Do* Matter

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Recent Black deaths at the hands of law enforcement officers has heightened awareness of racism within the United States. The consequences of this racism are not only differential policing practices toward Black people, but also inequities related to numerous other sectors, including housing, education, economics, and overt health care disparities between White and non-White Americans. Health care practitioners, including pharmacists, are extremely well positioned to be leaders in addressing long-standing inequities, thereby saving lives and improving access to and quality of care. The views of two senior faculty administrators are outlined: one, a White faculty member of privilege, the other, a Black CEO Dean. Despite having very different life experiences, they partner to foster unity and an antiracist culture within their institution and among their many stakeholders, with the ultimate goal of creating a culture of equity regardless of skin color.

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The Black Lives Matter movement originated with a Facebook post by Alicia Garza following the death of Trayvon Martin and the subsequent acquittal of his killer, George Zimmerman.¹ The words “Black lives matter,” which have permeated our lives in recent months, are not merely a slogan, but a declaration and affirmation that Black lives *do* matter. At a time when racial polarity is gripping our nation after the deaths of Ahmaud Arbury, Breonna Taylor, George Floyd, Rayshard Brooks, Daniel Prude, and countless other unnamed Black Americans, it is important for each of us to think about our personal perspective on racism in the United States. Only then can we begin to achieve the ideals of a nation for all citizens, not merely those of privilege. This commentary offers two unique perspectives on racism by senior administrators at the University of Tennessee Health Science Center (UTHSC) College of Pharmacy. One is offered by a White, male, clinical pharmacist and educator whose career spans over 40 years. The other is rendered by a Black, female, seasoned faculty member, former department head, researcher, executive director, and CEO (Chief Executive Officer) dean with more than 25 years of academic experience. The goal of sharing these perspectives is to provide context for their partnership and efforts to achieve racial awareness, literacy, unity, and

eventually equity at their academic institution. If individuals can identify to some degree with the views of either one of these two professionals whose social experiences represent opposite ends of the spectrum, an environment of inclusivity, equity, and diversity may be achieved among us all.

Perspective of Bradley A. Boucher, PharmD

I grew up in a predominantly White, blue-collar community on the northside of Minneapolis, where I attended public schools. During these years (1960s-1970s), it was evident to me that Minneapolis did indeed have segregation. The inner-city neighborhoods to the north and south of downtown Minneapolis clearly had a higher degree of poverty than the neighborhood I resided in, as well as a very different demographic make-up, ie, one of predominantly Black residents. What I did not know until recently, however, was that racial residential covenants existed in many communities within Minneapolis and its adjacent suburbs throughout much of the 20th century.² These covenants *de facto* created racial boundaries, and this segregation, supported by the courts until the 1960s, continues to have a ripple effect even today. The overall intended effect was to enrich White homeowners while impoverishing Black communities. This, in turn, undoubtedly has affected the quality of education and health care available to the citizens living in these communities. Nevertheless, I gave little thought to how advantaged I was by being able to attend the predominantly White schools in my neighborhood vs the

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inner-city Minneapolis schools that the majority of Black students attended. I do not recall thinking about the privileges afforded by my “Whiteness” (also known as *white privilege*, which is defined as “the unearned, mostly unacknowledged social advantage White people have over other racial groups simply because they are white”).³ In contrast, I believed strongly in the myth of American meritocracy for *all* at that time, firmly believing it was only one’s work ethic and discipline that stood in the way of future success. Eventually my efforts facilitated completion of my professional pharmacy training at the University of Minnesota College of Pharmacy. Thereafter, I began my academic career at the UTHSC College of Pharmacy in 1984, and moved to Memphis, a city with a majority Black population. While Memphis demographics were very different than those of my home city of Minneapolis, the ability of privileged White citizens to orchestrate neighborhood segregation was virtually indistinguishable.⁴ As in Minneapolis, the segregation of Black citizens into neighborhoods with subquality housing had spawned poverty and diminished their access to quality health care and education.⁴ This tactic was and continues to be the norm across the United States.

On an individual level, the question I now ask myself as a relatively successful senior faculty member is: did I achieve this success as a result of good fortune, hard work, the color of my skin, or a combination of these and other factors? In other words, would I have had the same success if I had been a Black man and not enjoyed a life of privilege? I certainly had more advantages because of my skin color. Furthermore, my three sons who are all health care professionals have also enjoyed White privilege. While I have never thought of myself as a “racist,” neither have I consciously acted to reverse the system of advantage based on race that exists in our society, past and present. Therefore, depending on one’s definition, I may have to accept the “racist” label along with all other White Americans who actively or passively enjoy lives of privilege.¹

While I have no guilt or shame regarding the privilege being White has provided me and my offspring, I have committed myself to becoming immersed into a heightened awareness of racism in the United States. The sentinel events leading to this commitment are the two Black deaths in or near my hometown of Minneapolis, a city I love. The first was the shooting of Philando Castile during a routine traffic stop in 2016. The other was the killing of George Floyd at the hands of a White police officer in May 2020. How could either of these deaths occur in the city that I grew up in? The answer is that structural racism continues to thrive there and in cities like it across America. These tragedies, and many others, are

at the forefront of the Black Lives Matter movement. Furthermore, countless Black Americans lose their lives because of health care disparities tied to racism. Because these Black lives do matter, it is time that we as pharmacists serve as advocates and agents of change to eliminate health disparities and health care disparities and promote a culture of equity for Black Americans and other persons of color.

Perspective of Marie Chisholm-Burns, PharmD, MPH, MBA

I grew up in a city in New York where the high school graduation rate was less than 30%, my parents never earned more than \$20,000 a year, and neither graduated from high school. My parents worked hard but also endured unimaginable prejudice in their efforts to make a better life for themselves and me. I vividly remember being with my father on repeated occasions when his gas station was set on fire and vandalized, with racial slurs scrawled on the walls. My parents instilled in me the will to focus on the business of survival and staying clear of any signs of trouble, including “good trouble” (which refers to acting as an agent for social change and justice, even if it causes disruption or defies authority).⁵ Although my parents were the best parents anyone could ask for, their moral character was unimpeachable, and my focused approach to better my circumstances was immensely valuable and life changing, over the years I have learned that I must address inequities (defined simply as injustice or unfairness⁶), which may challenge boundaries. With the disturbing events of this year, whenever I hear stories of racism, oppression, and brutality, I am haunted by a gas station on fire and the story of devastation and loss written on my father’s face. So today, as my dear colleague, Dr. Boucher, reflects on his life journey, I must in order to survive and move forward, reflect on the sunrise.

The morning after Congressman John Lewis and Reverend C.T. Vivian died, I watched the newscast reflecting on their lives, tears streaming down my face as I realized two icons had left us. However, their legacy of “keeping your eye on the prize”⁷ will continue, just as the sunrise continues. This year served as a watershed moment in which the eyes of the public have been opened, not only to the existence of racial inequities, but also to the pervasiveness and depth of racism in the United States. The country is struggling with crises on multiple fronts: the COVID-19 pandemic and the strain and pain it has caused our health systems and personal lives; health disparities, particularly among Black and Hispanic Americans, tragically exposed by the onslaught of the pandemic; and underrecognized, uncorrected, and untreated racial traumas experienced by Black Americans.

These racial traumas have existed since the birth of this country, accumulated over the decades, and include (but are not limited to): slavery, Jim Crow laws, the practice of “redlining,” mass incarceration, police brutality, food apartheid, educational disparities, economic gaps, microaggression, and additional traumas extending beyond the scope of this commentary, but experienced in mine and other African Americans’ daily reality.⁸⁻¹²

Racism exists in many forms, and includes *biological racism* (the belief the races are biologically different and that White people are superior), *ethnic racism* (the belief that the origins of various ethnic groups are different from one another and that one group has greater ability than other groups because of their ethnic origin), *bodily racism* (the belief that Black people are more physically dominant, violent, and threatening), and *cultural racism* (the belief that the Black culture is inferior to other cultures).¹³ Furthermore, the term *structural racism* is commonly used today, breeding the formation of ill-formed stereotypes and racist behaviors toward an individual ascribed to a certain group as a whole and, in reciprocal, the group or the “system” is responsible for the behavior of the individual.¹³ Structural racism perpetuates discrimination with little energy from individuals as it is inherently built into daily operations across government agencies, institutions, health systems, educational systems, and other myriad structures, and driven by culture, environment, practice, and policies of the system, organization, and/or program. Additionally, I also believe that structural racism or institutional racism masks the core of the problem and reduces racists’ ownership of creating, implementing, facilitating, and capitalizing on racist practices. It exonerates the individual of responsibility to change, preserves power, and even perpetuates further racist behaviors. Moreover, it relieves all individuals, including racists, of the responsibility for correcting the inequity. No doubt structural racism exists and should be eradicated. As Ibram X. Kendi declares and as Dr. Boucher appreciates, if you are not practicing anti-racism (defined as the belief that all people are equal and fighting to deconstruct racism), you are racist.¹³

Martin Luther King, Jr., suggested decades ago that the greatest stumbling block toward liberation is moderates who prefer a negative peace that is free of any tension, including uncomfortable conversations, and absent of real actions leading to racial equity.¹⁴ Just as Dr. Boucher reflects on his internal dilemma of White privilege, I too have reflected on my own “dueling consciousness”¹³ in order to both embrace my heritage and conform to the society that I want to be accepted in, and wonder if I could do more to fight inequities. As founder and director of the Medication Access Program, I help to increase medication access

among those who have limited access to needed medications, and the majority of my patients are persons of color. Is there more I can and should do in this area? Although I have some degree of privilege as a CEO Dean, my skin color continues to be one of the first things people notice about me, before they ever think about checking my credentials (if they check my credentials at all). Even as a well-educated Black woman, aggressions occur, not as open attacks like my father’s burning gas station, but as the more common microaggressions often experienced by Black Americans today. I often wonder what I would have been if I had all the privileges of a White male. However, wasting energy on wondering “what if” is not a fruitful exercise. Instead, I choose to move forward using whatever privilege I have in my circle of influence including my institution, UTHSC College of Pharmacy. Our minority student population has certainly grown during my tenure and is now greater than 40%. Dr. Boucher and I are clearly different, but for almost a decade we have worked together at UTHSC, along with many others, to help forge a path for our college to uphold a culture of diversity, and now we must commit to do more to resolve inequities.

Recently, I published a commentary in the *American Journal of Health-System Pharmacy* where I framed racism as a disease not dissimilar to COVID-19.¹⁵ To effectively treat a disease in a patient, the first step is to diagnose or recognize the problem. Likewise, the first step to changing the culture within a society regarding racism is to acknowledge the problem, regardless of one’s life journey and where one falls presently on the continuum from racist to antiracist. Thereafter, one needs to be intentional and committed to attitudinal change on an individual level. This is based on the assumption that one can grow toward development of antiracist behaviors, which in turn can lead to institutional initiatives focused on promoting inclusiveness, diversity, and equity.¹³

What treatment (medicine, if you will) can we start working on today to treat racism? A few proposed strategies include:

Identify the problem and call it out. What symptoms are being displayed? What behaviors are adversarial? What behaviors are producing the inequities and promoting racism?

Have the uncomfortable conversations that lead to reflection and a treatment plan. We must approach treatment from multiple perspectives or symptoms, including treatment plans to eliminate microaggressions and disparities/inequities concerning health care, education, socioeconomic, employment, law enforcement, and housing, to name a few.

Get to know people who are not like you. Push yourself out of your comfort zone.

Extend radical empathy, defined as “actively striving to better understand and share the feelings of others.

To fundamentally change our perspectives from judgmental to accepting, in an attempt to more authentically connect with ourselves and others.”¹⁶

Learn as much as possible about racial inequities and how to be an antiracist. In particular, White and non-White Americans must be intentional about being allies and advocates related to achieving equity and justice within communities across the United States.

Also, we must never take for granted the importance of leadership because leadership does matter.

*Treat people as you want to be treated, and once learning more about the individual, treat them as they want to be treated (which may be different than how you want to be treated).*¹⁵

Strive toward reducing disparities within your spheres of influence, including calling attention to policies, practices, and systems facilitating inequities.

Promote resilience as we strive toward equity. This is a marathon, and engagement is long-term.

One major initiative at our college has been the recent creation of the Equity, Inclusivity, and Diversity Advisory Board (comprised of faculty, staff, and student pharmacists) to swiftly identify goals and action items to promote an empathetic, attentive, and healing environment. Some early successes are several curricular changes related to health care disparities, diversity, and inclusion; virtual social gathering and “listening sessions” with approximately 150 and 125 college participants in the first two offerings, respectively; and requiring all faculty and staff members to complete formal diversity training programs. While the majority of the action items of the Board are inwardly focused on the environment at the UTHSC College of Pharmacy and our many stakeholders, such as our student pharmacists, faculty, staff, and alumni, the overarching goal is to affect the patients we serve and society as a whole. In doing so, we support that “Black lives *do* matter” in addition to upholding the well-being of all persons less privileged. The sun has risen, and it is a new day with a better tomorrow ahead.

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