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COMMENTARY

Socialized and traumatized: Pharmacists, underserved patients, and the COVID-19 vaccine

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ABSTRACT

The coronavirus disease 2019 (COVID-19) pandemic has brought attention and awareness to existing health disparities in underrepresented minority communities. Not only were minoritized populations disproportionately and negatively affected by COVID-19, but a history of mistrust and other systemic barriers prevented access to treatment and testing and even affected access and acceptance of the current vaccines.

Pharmacists are essential to the provision of care for the general population, particularly during global crises. Minoritized pharmacists play an even greater role as partners with public health officials to translate science and build trust in minoritized community members who are hesitant about vaccine development, safety, and efficacy. Dedicated to representing the views and ideals of minority pharmacists on critical issues affecting health care, the National Pharmaceutical Association (NPhA) has been at the forefront of the pandemic. Throughout the pandemic, NPhA has prioritized the role of underrepresented practitioners, striving to improve awareness and access to underrepresented communities. While delivering education and information about the COVID-19 vaccine, clinical trials, population prioritization, and federal funding to our service areas and target populations, NPhA continues to challenge health care myths and address historical conflicts and systemic racism that often dictate the access to treatment and quality health care.

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On February 3, 2020, the United States announced a public health emergency owing to coronavirus disease 2019 (COVID-19), and on March 13, 2020, the World Health Organization (WHO) declared COVID-19 a pandemic.¹ As the world struggled to implement treatment protocols and preventative measures, the death count steadily increased. Today, more than 500,000 deaths have been reported in the United States.²

The COVID-19 pandemic brought attention and awareness to existing health disparities within marginalized communities. Populations of color are disproportionately and negatively affected by COVID-19. Hospitalization rates are 2.9 times higher among non-Hispanic Black/African American persons

and 3.1 times higher among Hispanic or Latino persons.³ Among Black/African American and Hispanic/Latino populations, death rates were 1.9 times higher than whites.³ Moreover, Black/African American practitioners are still defined by the color of their skin rather than the content of their character, depth of knowledge, or expertise.⁴ As such, they are subject to the same consequences of structural racism and bias that their minoritized patients face and can themselves harbor mistrust in health care systems and vaccines overall. Black/African American pharmacists, in particular, live at the intersection of their racial traumas and professional obligation to inform and protect the public regarding their health. Being one of the most trusted and accessible health care team members places them in a unique position of influence. However, when Black/African American pharmacists do not trust or lack confidence in the health care system, they cannot readily encourage their patients' participation in clinical trials or receipt of the vaccine when offered. Yet, in the context of medical mistrust and COVID-19 vaccines, representatives from minoritized groups are the best voices to convey the message to minoritized communities. Minoritized

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Key Points**Background:**

- Pharmacists are essential to the provision of care for patients during the coronavirus disease 2019 (COVID-19) pandemic.
- Pharmacists have a unique and vital role to play in pandemics and disasters.
- The National Pharmaceutical Association represents the views and ideas of minority pharmacists on critical health issues.

Findings:

- Explain the complexity of the COVID-19 vaccine among underrepresented groups (e.g., hesitancy, limited access).
- Inform pharmacists and health care practitioners on steps and strategies to understand vaccine hesitancy and meet the needs of and serve underrepresented patients.

health professionals are critical partners with public health officials to translate science and build trust in minoritized community members who are hesitant about vaccine development, safety, and efficacy. The message and the messenger can affect the response of the patient. Better health outcomes are achieved when there is racial concordance between the patient and the provider owing to greater trust.⁵

Unhealed trauma remains in the bodies of minoritized populations and is passed from generation to generation genetically and behaviorally.⁶ Medical mistrust is different from medical distrust. Whereas distrust implies an absence of trust or doubt and suspicion stemming from experience or specific knowledge, mistrust is a lack of confidence based on feelings or instincts instead of informed expertise or opinion.⁷ Medical mistrust within the Black/African American community originates from interpersonal and institutionalized racism, which continually reproduces anti-Black sentiment within the society. Many studies cite the Tuskegee Study of Untreated Syphilis in the Negro Male (TSUS) as the primary source of Black/African Americans' mistrust of the U.S. health care system.⁸⁻¹⁰ However, there were several unethical, inhumane, and abusive practices rooted in white supremacy that led to the design, implementation, and evaluation of TSUS. During the Jim Crow era, the contemporary belief was that the health disparities surrounding high mortality rates within the Black/African American community were due to their inherent genetic inferiority and not the lack of access to quality health care services and other resources that affected health as the cause.¹¹ These historical injustices led to generations of Black/African Americans being socialized in an environment that perpetuates medical mistrust.^{9,10} Often, this message is merely passed down generationally in oral history from parents and grandparents. The medical mistrust created by these previous unjust practices has important consequences for contemporary practice.

Vaccine hesitancy, or delayed acceptance or refusal of vaccination, is one such consequence of the systemic failures and mistrust in the United States. Clearly defined within the 3C model, created by the WHO EURO Working Group on Vaccine Communications, 3 components characterize hesitancy (i.e., confidence, complacency, and convenience).¹² The lack of confidence in the vaccines themselves, the systems that administer vaccines (e.g., health systems and practitioners), and the motives of political leaders have all been cited as primary causes for the delayed uptake in minoritized communities.^{12,13}

In response to the pandemic, the U.S. government launched a project called "Operation Warp Speed" to produce vaccines, therapeutic agents, and diagnostic tests.¹⁴ There was much enthusiasm in December 2020, when 2 vaccine candidates made by Pfizer/BioNTech and Moderna were granted emergency use authorizations by the Food and Drug Administration. With greater than 90% efficacy reported for each vaccine, the possibility of returning to pre-COVID-19 days was on the mind of Americans.^{15,16} Tempering the enthusiasm was the fear that political involvement, pharmaceutical lack of transparency, and a rapid development and authorization process might have compromised safety.¹³ The operation's name caused concern that speed rather than safety and efficacy would be the priority. Recognizing the public's concern regarding vaccine safety, chief executive officers of 9 pharmaceutical companies issued a joint statement to assure that they were committed to high ethical standards and scientific rigor and would not compromise on safety.¹⁷

Dedicated to representing the views and ideals of minority pharmacists on critical issues affecting health care, the National Pharmaceutical Association (NPhA) has been a trusted voice during the COVID-19 pandemic. NPhA is a professional pharmacy organization founded in 1947 by Chauncey I. Cooper, promoting racial and health equity.¹⁸ NPhA amplifies the unique health care needs of Black and Brown communities heightened by COVID-19 by challenging health care myths, educating patients, addressing historical conflicts, and exposing systemic racism. NPhA collaborated with the National Medical Association (NMA) and a panel of Black/African American health care practitioners to vet the COVID-19 vaccines and treatments independently through the NMA COVID-19 Task Force on Vaccines and Therapeutics (NMA CTFVT).¹⁹ This task force evaluated the vaccines for safety and efficacy in addition to the clinical trial processes. Black/African American health professionals and experts from NPhA, NMA, historically black colleges and universities, professional, government, civic, and community organizations conducted informational sessions individually and collectively using various platforms to educate minoritized communities about COVID-19 and the benefits of a vaccine. Members of NMA CTFVT helped address concerns regarding the development, technology, adverse effects, and efficacy of the vaccines and vaccine candidates.²⁰

Despite the efforts of several organizations, vaccine hesitancy continued to rise, even among health professionals. There are higher rates of COVID-19 vaccine refusal among health care workers from minoritized populations.¹³ Hesitancy, coupled with limited vaccine access, inequitable allocation, and distribution efforts, widened racial disparities.²¹ Despite communities of color being disproportionately affected by

COVID-19, data have shown that Blacks and Hispanics received fewer vaccinations than whites and higher total positive cases and deaths.²² Although diverse populations of frontline health care workers and nursing home residents were among the first to receive doses of the newly authorized vaccines, barriers to appointments (e.g., online registration) and transportation to mobile clinics further widened the equity gap.^{23,24} Recognizing the need for timely reporting of demographic information and parity and equity in the distribution plan, the federal administration has partnered with local community health centers to prioritize communities of color, low-income communities, and other underserved populations.²⁵

Heeding the call to amplify the unique health care needs of underrepresented communities and pharmacists, NPhA collaborated with other national pharmacy organizations to develop a plan to address the role of the pharmacist in COVID-19 testing and vaccinations. The collaboration resulted in an executive summary titled “Pharmacists as Frontline Responders for COVID-19 Patient Care.”²⁶

NPhA has pharmacists who are well trained, experienced, and are ready to take the lead in ensuring that minoritized populations are informed about COVID-19 and have access to tests, treatments, and vaccines.

Steps to ensure that patients from minoritized communities are best served are as follows:

- (1) Pharmacists should collaborate with other minority health professionals and minority community organizations. Collaboration allows each group to have a wider reach. Hearing the same message from different health care practitioners and patient advocates deepens the impact.
- (2) Pharmacists can extend their reach and increase their effectiveness if they identify and educate key individuals in minoritized communities. COVID-19 vaccine education requires strategic partnerships to increase awareness and acceptability of the data presented. Provision of culturally and linguistically appropriate messaging is vital to all communities of color. Practitioners who speak the same language as the patients increase the likelihood that messages acknowledge appropriate norms and idioms.
- (3) Pharmacists from minoritized populations must acknowledge and address their own history, pain, and trauma. The transparency around shared experiences brings an authenticity that can validate the message and the messenger. Reconciliation of internalized racial trauma allows minoritized pharmacists to listen to, empathize with, motivate, and mobilize their minoritized and marginalized patients.
- (4) Pharmacists from non-minoritized communities must educate themselves about the history, pain, and survival of minoritized practitioners and patients. To rely on practitioners of color to teach as experts on cultural diversity can create additional cultural taxation on the minoritized practitioner. Therefore, self-education and self-exploration are encouraged for non-minoritized pharmacists.
- (5) Health professional teams need to be diversified. The representation of practitioners from minoritized populations in pharmacy is not proportional to the general U.S. population. This imbalance results in the loss of

benefits achieved when there is racial concordance between patient and practitioner.

- (6) Health professionals must advocate for an equitable roll-out of the available vaccines. Distribution efforts that do not acknowledge and address the limitations and barriers to uptake in rural and marginalized communities are shortsighted and disingenuous. Logistics and roll-out teams must address and compensate for the limitations imposed by pharmacy deserts or medically underserved areas to reach and serve the negatively affected communities.
- (7) Minoritized pharmacists can demonstrate confidence in the available vaccines by sharing personal images or stories of themselves receiving the vaccine. Increased awareness of the participation of minoritized persons as manufacturers, research scientists, educators, and clinical trial participants spurs conversation and confidence. Having multiple trusted individuals at various points in the research process, including roles on data safety monitoring boards; vaccine review panels; regulatory agencies; and federal, state, and local health departments strengthens the confidence of historically marginalized populations.

Black/African American health professionals stand at the intersection of being racialized, minoritized, and traumatized. Although proven resilient through tribulations such as slavery, medical experimentation, and Jim Crow, these professionals carry the burden of lived experiences in a system of oppression and structural racism and stand in the gap with the knowledge and connection to the community to affect systems of change. As pharmacists, we must stand in solidarity with other practitioners, legislators, and public health organizations to address health disparities. NPhA is willing and ready to lead and coordinate such efforts.

Glossary

- Disadvantaged/excluded/marginalized/vulnerable groups or populations: terms applied to people who, owing to factors usually considered outside their control, do not have the same opportunities as more privileged groups in society.²⁷
- Minoritized: recognition that systemic inequalities, oppression, and marginalization place individuals into ‘minority’ status rather than their own characteristics and acknowledge the understanding that minority is socially constructed. These systems sustain the overrepresentation and dominance of historically privileged social identities.²⁸

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