A Profession Gone Astray: The Hidden Truth about DEI in Pharmacy

By Daniel Brown

If it ain't broke, don't fix it.
Corollary: Don't claim it's broken as an excuse to "fix" it.

A Trustworthy Profession

The annual Gallup survey that ranks the public's perception of their trust in various professions perennially places pharmacists at or near the top. No surprise. Pharmacy is a service profession that is based on fiduciary relationships. The function of pharmacists is to serve the needs of their patients. Fiduciary relationships are built on trust, in which the beneficiaries (patients) entrust their health and wellness to the professional expertise of the fiduciary (pharmacist).

Fundamental to the fiduciary relationship is the assumption that the pharmacist's commitment to providing quality professional service is unconditional and without exception, regardless of a patient's race, religion, gender, sexual orientation, or ethnicity. Patients of any identity group can reliably expect to receive quality care from their pharmacists, because the professional responsibility of pharmacists has no limitations or exclusions. A patient's need for care is the sole determinant of the pharmacist's duty to serve that need to the greatest extent possible.

Though it was not in a health care context, Jesus illustrated the concept of serving the needs of others, without regard to racial, religious, or ethnic differences, in the parable of the Good Samaritan. Luke 10:30-37 conveys the significance of a priest and Levite ignoring the needs of a man who had been beaten, robbed, and left to die by the side of the road between Jerusalem and Jericho. Later, a Samaritan passed by and took pity on the injured man. Even though Samaritans and Jews had been in bitter conflict for many years and wanted nothing to do with each other, the Samaritan ignored any feelings of hostility and saw to the man's injuries. He even transported the man to safe shelter so his wounds could heal. The Samaritan's actions were an example of unconditional service, born from a sense of compassion for another human being. He paid no attention to the identity group of the injured man. Jesus told this parable in response to a question about what it means to love your neighbor.

The overwhelming majority of pharmacists function consistently as "Good Samaritans" and trustworthy professionals toward their patients. And yet, some within the profession believe it to be systemically afflicted with racism and discriminatory prejudice against a variety of marginalized groups, claiming that disparate care results from the inherent biases of pharmacist practitioners. They further demand that pharmacy employers require employees to undergo diversity, equity, and inclusion (DEI) training and that pharmacy schools incorporate DEI throughout the PharmD curriculum. In their minds, the quality of care is a function of the identity group to which a patient belongs. Supposedly, members of privileged groups receive good care and those belonging to marginalized, disadvantaged, or under-represented groups, receive sub-standard care.

An Alternate Reality: My Pharmacy Story

For me, pondering such an assertion is cause for mind-numbing cognitive dissonance. Can it really be that the quality of care provided to patients is a function of the level of prejudice that the pharmacist exhibits toward the patient's identity group? My experience belies the negative connotations behind the common DEI narratives swirling about. I am a proud member of one of the most infamous identity groups in the history of modern health care—retired baby boomers. Our arrival was anxiously anticipated for decades, but once we appeared on the scene, it became readily apparent that the looming calamity had been a bit overblown. It is reminiscent of the ominous foreboding associated with the Y2K fiasco.

I have always been a boomer, but I have not always been a retired boomer. I was a pharmacy practitioner or manager from 1981 to 2001, working exclusively in public hospitals. The health care professionals in those hospitals provided the best possible care to all patients, many of whom were medically indigent. We served a highly diverse patient population. Regardless of one's outward appearance, racial/ethnic background, socio-economic status, or lifestyle choices, if you came through the doors of our hospital, we did our best to serve you.

In 2001, I transitioned from pharmacy practice to academia, where I spent the next 19 years engaged in a variety of faculty and administrative roles. Every year, we managed to enroll an incoming class that had been thoroughly vetted to rigorous academic standards. Each class was also highly diverse—not by design or intention, but as a natural reflection of the applicant pool—based on fair, unbiased admissions practices that focused on qualifications.

That is why I was taken aback in 2020, while easing into retirement, to learn of accusations that my profession was afflicted with systemic prejudice and discrimination. After almost 40 years of witnessing colleagues serve with the utmost compassion and devotion to professional duty, such a sweeping indictment of an entire profession was hard to fathom. It struck me as a gross mischaracterization that was unfounded, unjust, and unhelpful.

Nevertheless, I found myself having to face the possibility that I have spent an entire career oblivious to a deep-seated pattern of systemic bias within my profession. Or could it be that some pharmacy employers and educators have fallen victim to a prevailing false narrative that lacks legitimate evidence to support radical claims of systemic racism, widespread discrimination, and oppression? The crux of this dilemma boils down to a matter of trying to separate fact from fiction regarding diversity, equity, and inclusion, as well as the actual causes of health care disparities.

Disparities in Health Care

It is widely known that health care disparities exist in the US. Whether health coverage is provided by Medicare, Medicaid, private insurance, the Veteran's Administration, or other entity, some people have access to better care than others. Some receive medications or therapies that others cannot. Some receive care rapidly; others must wait longer periods. Some have procedures approved; others have them denied.

The root causes of health care disparities are multifaceted and extremely complex. Differences in socioeconomic factors, education, lifestyle habits, nutrition, body weight, physical activity, living conditions, family life, genetics, race, ethnicity, gender, and medication/therapy adherence, all play a role. However, the presumption that substandard care results routinely from racist or discriminatory behavior toward members of marginalized groups is patently false. The claim that systemic racism is the root cause of disparities in health care and education only serves to divert attention away from legitimate issues that need to be addressed. If progress is to be made in resolving disparities, it is imperative that cause-effect relationships be correctly identified. Otherwise, the solutions will not match the problems they are intended to fix.

Sensible Diversity Efforts Predated DEI

Well before the DEI movement was born, diversity was already valued and promoted throughout the profession of pharmacy. The idea of broadening representation from a wide range of groups was deemed worthy of pursuit. Outreach efforts encouraged members of minority groups to explore the possibilities of a career in pharmacy. At that time, diversity activities were based on cultivating interest and attracting applicants from groups that, historically, were not well represented in pharmacy.

To improve the quality of pharmacy services provided to minority patients, PharmD curricula included coursework and experiential activities geared toward promoting an appreciation of, and sensitivity for, cultural, ethnic, spiritual, racial, sexual, and socioeconomic differences that might affect the ability of a pharmacist and patient to effectively relate to one other. It was widely recognized that pharmacists needed to understand the unique needs of a highly diverse patient population, in ways that extended beyond language barriers. The term "cultural competency" was used to represent the vast array of professional skills that are required to effectively serve a broad patient population. Unfortunately, cultural competence in the era of DEI is no longer considered sufficient for dealing with the extreme cultural issues of the day, which call for revamping social systems rather than improving interpersonal dynamics.

Influences of Critical Race Theory (CRT)

In the late 1990s, CRT emerged as a major ideologic force. It is rooted in the belief that racism is, and always has been, systemic in the US, with Whites universally oppressing Blacks and other minorities. CRT does not distinguish between the personal behaviors of individuals and their identity as part of a racial group. Every member of an "oppressor" group

is guilty of racism and every member of an "oppressed" group is an innocent victim. No consideration is given to personal responsibility or accountability.

CRT also disregards differences in context between past racism and present racism. Racism was systemic then and it is systemic now. The effect of equal rights laws and regulations that have been enacted since the 1964 Civil Rights Act are said to be insufficient and irrelevant. According to CRT dogma, even if Whites do not engage in overt acts of racism, they are guilty of "implicit" racism by virtue of the "microaggressions" they subconsciously perpetrate against their oppressed victims.

CRT proponents claim to be able to measure the unconscious bias of Whites using a psychosocial measurement tool called the Implicit Association Test (IAT).[1] It is based on the assumption that when shown a photographic image and a descriptive word or phrase, a test subject will rapidly associate the two if the association represents an implicitly held belief. If the association is not implicitly held, the response will be slower, because it requires a cognitive decision to be made. The IAT presumably shows that Whites are guilty of implicit racism, although the validity and reliability of the psychometric instrument have not been verified.[2] Nevertheless, it is impossible to refute an accusation of implicit racism because the possibilities of alleged microaggressions are limited only by the imagination of the accuser, and the presence of any legitimate evidence, either incriminating or exculpatory, exists only in the mind of the accused.

CRT rejects the notion of "colorblindness" and ignores the dream of Dr. Martin Luther King Jr., that people be judged by the content of their character, not the color of their skin. CRT methods reward skin pigmentation and punish the lack thereof. In comparing CRT to the civil rights movements of the 1960s, the emphasis has shifted from creating equality to acquiring and exerting power.

Hidden Agenda of DEI

DEI is grounded in the same ideology as CRT, but with an expanded scope of oppressed groups that extends beyond race. The unspoken purpose of DEI is to sow seeds of conflict and division between people who are labeled as oppressors and those who are said to be victims of the oppressors. The "oppressor vs. oppressed" dynamic originated with classic Marxism, which distinguished between oppressor and oppressed on the basis of socioeconomic class—the oppressive bourgeoisies vs. the oppressed proletariats.[3] The caste systems of Europe provided ideal conditions for exploiting such conflict, because one's social class (and, therefore, status as oppressor or oppressed) was essentially fixed at birth. There was virtually no chance of economic mobility.

DEI reflects the same Marxist philosophy of oppressive conflict, but with a major twist.[3] America, being the land of opportunity, does not conform to a fixed social class system. There are numerous examples of rags to riches stories in which people have overcome humble beginnings to become wealthy and influential. Therein lies the problem with applying economic Marxism within a capitalistic democracy. No one in this country is locked into a state of oppression because everyone is free to improve their economic status. The Marxist precept of fixed systemic economic oppression is thereby negated.

DEI shifts attention away from socio-economics to a new "neo-Marxist" version of the original ideology, which focuses instead on the oppression of a variety of identity groups that are distinguished by fixed characteristics, such as race, skin color, ethnicity, religion, sexual orientation, and gender.[3] DEI identifies the "oppressor" groups to be Whites, males, Christians, Jews, heterosexuals, cisgenders, and non-transgenders. Members of contrasting groups qualify as "the oppressed." The oppression of those who belong to multiple groups is correspondingly multiplied by each intersection. Such overlap is termed "intersectionality."

A major aim of DEI is to actively subvert the oppressive social order by exercising power to change systemic policies, such that the relationship between oppressor and oppressed is upended, and oppressors are forced to succumb to a new social order in which they are no longer privileged.[3] This societal transformation is accomplished, in part, by convincing oppressors that they have been oppressive, and using their guilt to coerce them into becoming activists for the cause. This is how nebulous concepts, such as implicit/unconscious bias and microaggression, have become tools of coercion, because accusations can assign guilt without evidence, and the accused have no way to defend themselves.

The syndrome of White guilt has been termed "White fragility," and the cure is for a White oppressor to become an "antiracist." As CRT authority, Ibram X. Kendi,[4] explains, *"The only remedy to negative racist discrimination that produces inequity is positive antiracist discrimination that produces equity."* Essentially, his words imply that there is

"bad" discrimination, which tilts the scales in favor of privileged groups (inequity), and "good" discrimination, which tilts the scales in favor of disadvantaged groups (equity). From this perspective, the desired outcome is not to eliminate discrimination, but to ensure that it only benefits oppressed groups.

Kendi goes on to describe his concept of antiracism in the following way,[4] *"What's the problem with being "not racist"? It is a claim that signifies neutrality: "I am not a racist, but neither am I aggressively against racism." But there is no neutrality in the racism struggle. The opposite of "racist" isn't "not racist." It is "antiracist."* Kendi's vision of the antiracist is one who will fight against the power structures and policies that maintain systemic racism and oppression. It is not good enough to not be racist, one must become an activist striving to fix disparities in the social order, by redirecting discriminatory practices from inequity to equity, and conferring advantages upon traditionally disadvantaged groups.

Rise and Fall of DEI

The DEI movement has been in a growth mode for several years and expanded sharply amid the heightened racial tensions of 2020. Businesses, corporations, schools, and universities established DEI departments, hired DEI officers, and enacted DEI policies, in pursuit of a DEI agenda. Processes for hiring employees and enrolling students were designed to eliminate supposed partiality toward privileged groups and achieve greater representation from marginalized groups. In health care, DEI is promoted as a means of creating a greater diversity of providers, one that is closer to the proportionality of the population. It is based on the assumption that health care disparities will dissipate if patients are treated by providers who belong to the same identity group. Historically, this has been accomplished through various types of affirmative action programs that give preference to under-represented groups.

DEI programs also focus on training. A variety of programs are offered, some required, some voluntary, designed to inform participants about the tenets of DEI ideology, as well as topics such as racism, antiracism, White privilege, White fragility, White supremacy, implicit bias, microaggressions, and intersectionality. By their very nature, these topics tend to inflame passions and spur conflict, as members of marginalized groups gain deeper understanding of their victimhood and members of oppressor groups learn more about the demonic nature of their privilege. Whether in the world of business or academia, DEI training programs emphasize the necessity of systemic change, and often function more as a call to action than an educational lesson.

It is not surprising that DEI is starting to come under attack. Corporations are cutting back on DEI training and eliminating DEI departments and positions. Walmart, McDonalds, Ford, Harley-Davidson, Amazon, Lowe's, and Meta, have all made such announcements in recent months.[5] States are also taking action to prohibit DEI practices in state agencies and university systems. On January 14, 2025, the incoming governor of West Virginia, Patrick Morrisey, released Executive Order No. 3-25, which reads in part:[6]

"No department, division, agency, or board under the authority of the Governor, or any entity receiving state funds, shall utilize state funds, property, or resources to do the following: a) Grant or support DEI staff positions, activities, procedures, or programs, to the extent they grant preferential treatment based on one person's particular race, color, sex, ethnicity, or national origin over that of another; b) mandate any person to participate in, listen to, or receive any education, training, activities, procedures, or programming, to the extent such education, activity, procedure, or program, promotes or encourages the granting of preferences based on one person's particular race, color, sex, ethnicity, or national origin over that of another."

Seven states preceded West Virginia's actions last year, by enacting similar bans on DEI programs or defunding DEI initiatives at state universities.[5] Those states include Alabama, Idaho, Iowa, Indiana, Kansas, Utah, and Wyoming. Florida, North Carolina, Tennessee, Texas, and North Dakota, had already taken such action.

The DEI law in Utah[5] describes as discriminatory, such claims as, *"Meritocracy is inherently racist or sexist."* That sentiment is an absurd distortion of reality. Meritocracy is the incentivizing force that drives progress in a democratic, capitalistic society. It rewards the performance, rather than appearance, of individuals. The Utah law also identifies as discriminatory the opinion that, *"An individual, by virtue of the individual's personal identity characteristics, bears responsibility for the actions committed in the past by other individuals with the same personal identity characteristics."* If that sentiment were true, the entire population of the planet would be confined to prison. In Ezekiel 18:20, God makes it clear that people are personally responsible for their own sins, not for the sins of others, and especially not for sins committed before they were born.

The DEI law in Alabama, which also covers K-12 school systems, prohibits teaching divisive concepts, including, but

not limited to, the assertion that a person can be, *"inherently racist, sexist, or oppressive, whether consciously or subconsciously,"*[5] In Alabama, thoughts are not considered to be acts of oppression.

Reframing the Elements of DEI

It is time for pharmacy to rediscover the appeal of "cultural competence" as a central theme. Diversity should be cultivated as a natural outflow of greater tolerance and understanding between groups. With that in mind, the elements of DEI can be redefined into a more constructive set of priorities that emphasize universal values, such as quality, excellence, equality, merit, justice, and fairness.

From Diversity to Quality and Excellence. God's children represent every tribe, tongue, and nation on earth, and yet, constitute one body and one Spirit (Ephesians 4:4). Diversity has the potential to strengthen the social fabric through unity or weaken it through division. DEI highlights differences between identity groups via accusations of discrimination, oppression, and victimhood. Thus, diversity becomes a weaponized tool that can be exploited to produce conflict and pit groups against each other. From a professional perspective, the focus should be on quality and excellence, to ensure that every patient, regardless of identity group, receives the best possible care. When quality standards are upheld and excellence is the primary objective, diversity occurs naturally, and patients benefit from optimal care. When diversity becomes a forced construct, by instituting quotas or enforcing preferential standards, quality becomes a secondary priority, mediocrity replaces excellence, and patient care suffers.

From Equity to Equality and Merit. In the current DEI vernacular, equity refers to equal outcomes for all, meaning that everyone is entitled to the same degree of success. Equality, on the other hand, refers to having equal opportunity. According to DEI ideology, equality is a misnomer, because oppressed groups lack the advantages afforded to privileged groups. From that perspective, it is not a level playing field, and "equity" interventions are necessary to overcome the discriminatory disadvantages imposed on minority groups. The DEI solution is to make it easier for members of a disadvantaged group to succeed *(i.e., positive discrimination to achieve equity)*, by making exceptions, changing the rules for select groups, or establishing group-specific quotas.

Equity can be perilous in a professional context. Functioning as a competent practitioner is what matters. Therefore, entry into a profession must be earned on merit, proving oneself capable of practicing pharmacy based on individual performance—not group identity. Merit must be the primary determinant in being hired or gaining admission, even if it means that a proportional representation of groups is not achieved. Equality refers to having a level playing field on which to compete. If some people are not equipped to do so, the answer is not to alter the playing field (equity), but to address developmental factors that might have hindered them from adequately preparing themselves to compete on the same field as other competitors.

In the parable of the ten minas (Luke 19:12-27), Jesus described how the rewards of ten servants were based on merit, as reflected by what each had done with the mina given to them for safe keeping. In effect, it was an illustration of reaping what you sow. It did not matter what kind of circumstances the servants had previously experienced in life, or how much exposure they had to investment strategies or money management principles. They each had the same opportunity to succeed (equality) with the mina they were given, and each servant received a reward commensurate with the outcome achieved.

There is no better example of a merit-based system with natural diversity than professional sports. Though racial representation varies between sports, one factor holds true across all sports—only the best players at each position make the roster because those players give their team the best chance to win. In professional sports, equity gives way to merit, and the identity group of players is irrelevant. It is because of merit that Jackie Robinson successfully overcame the pervasive racism that existed in major league baseball 78 years ago. Since then, also because of merit, countless minority players in sports, such as basketball, baseball, and football, have gone on to become wealthy superstars with illustrious careers. Merit is a more powerful advancement tool for minority groups than affirmative action.

From Inclusion to Justice and Fairness. Inclusion, at first glance, is an innocuous term that reflects tolerance and a welcoming attitude. It correlates perfectly to the "Good Samaritan" nature of Christ's command to love thy neighbor. Inclusion speaks of peace and harmony. Everyone should have the opportunity to be included according to processes that are applied fairly and justly. DEI ideology, however, twists the concept of inclusion from a welcoming invitation into a forceful intrusion. According to DEI principles, oppressed minority groups must be included if they so desire, even if their inclusion creates hardships for others. Taken a step further, the right of an oppressed group to be included supersedes the right of a privileged group to even object to the inclusion.

DEI "Inclusion" issues often lack a rational justification, and advocates seem reluctant to provide a cogent argument in support of their demands. The topic is typically not open to debate. Moreover, there is a propensity in DEI circles to shut down those who express differing opinions, by personally attacking and slandering them with pejorative labels, such as racist, White supremacist, xenophobe, homophobe, transphobe, or misogynist. These tactics of defaming the individual rather than countering the argument embody an element of "cancel culture" that is predicated on manipulating behavior through fear, power, and intimidation.

Using transgenderism as an example, DEI policies require that biological males who believe themselves to be females must be allowed to compete in women's sports, regardless of how biological women in those sports feel about it. Forceful inclusion will never be an effective means of achieving functional inclusivity because it excludes the application of fairness and justice. Such is the case when the obvious physical advantages of biological men, even those transitioning, are discounted as being inconsequential in sports competition. Contrary to DEI assertions, the physical mismatch between men and women turns what should be a healthy sports competition into a pointless charade, all for the sake of inclusion. It is fundamentally unfair and there is no justice in claiming victory under such circumstances. The beauty of fairness and justice is that when properly applied, the result becomes a simple matter of common sense.

The Impact of DEI on Pharmacy

Over the last 10 years, DEI has embedded itself deep into the culture of pharmacy, with CRT as its backbone. DEI offices, administrative positions, and programs have become widespread in schools of pharmacy, pharmacy corporations, and health care institutions. The principles of CRT and DEI are shaping pharmacy practice and pharmacy education.

In 2017, a group of pharmacy faculty reported on their search for literature that addressed the topics of diversity, equity, identity, institutional culture/climate, or multi-culturalism.[7] They identified eleven publications, and concluded that there should be a greater emphasis on research of diversity-related topics. Shortly thereafter, a letter-to-the-editor criticized the original article for failing to include CRT in the analysis.[8] The letter stated, *"With respect to student pharmacists specifically, addressing CRT in diversity curriculum offers students the opportunity to recognize the causes and consequences of racism and articulate unjust practices against racially diverse people."* The letter went on the express that CRT, as an emphasis in pharmacy education, has the potential to, *"expand the dialogue on racism and develop a pharmacy workforce that will expose and advocate against racism in our health care system."*[8]

As a reflection of the continuing CRT influence on DEI, a fourth letter was added to form a new acronym—DEIA—to include "antiracism." A publication written by pharmacy faculty describes antiracism as follows, *"While often challenged by the notion of being "not racist," an antiracist rejects the seemingly neutral stance of being "colorblind" and supports policies and ideas that aggressively confront and reduce racial inequity."*[9] The authors call for racism to be taught as a root cause of health disparities and suggest that student pharmacists should be equipped to become antiracist practitioners.

In 2021, the AACP Board of Directors and the APhA Board of Trustees approved a revised version of the Oath of a Pharmacist, to include the following statement: *"I will promote inclusion, embrace diversity, and advocate for justice to advance health equity."*[10] Thanks to some deft wordsmithing, the addition to the Oath makes reference to all three elements of DEI and includes a subtle call to social activism. It is somewhat vague as to what is meant by, "advocate for justice to advance health equity." It is also unclear how "advocating for justice to advance health equity" constitutes a legitimate professional responsibility of pharmacists. Other than signaling support for the DEI movement, the revised Oath seems to have added little of substance to a document that was not in need of revision.

There are numerous examples of pharmacy literature calling for the teaching of antiracism and the need to increase awareness about issues that contribute to health disparity, such as White privilege, White supremacy, White bias, and White microaggressions. These topics all relate directly to the concept of White fragility, which addresses how Whites try to cope with the guilt of their privilege, racism, and oppression.

A group of faculty at the University of Minnesota College of Pharmacy published a report in 2022, describing their experiences with an in-class exercise about White Fragility with first-year students in a Foundations of Pharmaceutical Care course.[11] Students were asked to read a paper on White fragility before coming to class and answer two preparatory questions: 1) How can the college and you improve the capacity and stamina of Whites, so they are prepared to teach and initiate constructive patient engagement across racial divides? 2) Recognizing that emotions play

a critical role in learning, how does the information in the "White Fragility" article make your feel? Of the 157 students who responded, 65% were female, 66% White, 12% Black, and 24% Asian. Students reported seven categories of feelings: 49% awareness, 38% discomfort, 20% empathy, 17% defensiveness, 16% frustration, 12% empowerment, and 8% curiosity.

When trying to make sense of these results, one must consider the powerful influence of the academic hierarchy. Many students were probably reluctant to communicate their true feelings to a course instructor. From a broader perspective, this exercise was more telling about the mindset of the faculty who designed it and considered it to be appropriate. One can only imagine the feelings of insult, embarrassment, and intimidation experienced by White students when completing the survey and participating in follow-up discussions.

How can well-intentioned faculty painstakingly avoid words or actions that might be perceived as "microaggressions" toward non-White students, while deeming it acceptable to bluntly challenge White students to confront their privilege and racist tendencies? "White Fragility" is an unscientific, fallacious hoax that is used to intimidate, not educate. It does not belong in a PharmD curriculum. This is not a good look for the academy. Such misguided teaching creates a compelling argument that more universities should banish CRT and DEI from their classrooms.

CONCLUSION: Pharmacy is Better Off Without DEI

Pharmacists would be well advised to keep the profession focused on its fundamental mission, which is to provide excellent pharmaceutical care unconditionally. A service profession should not allow itself to be diverted toward becoming a social justice platform. Pharmacists face enough challenges without having to take on the additional burden of pushing for social change to advance a DEI agenda. Of course, pharmacists are free to engage in social activism if they so choose, but it should be a personal choice, not an expectation stated in a professional oath. To ensure that pharmacy remains true to its mission, pharmacists must open their eyes to the realities of DEI and CRT. The following observations are offered as a means of stimulating thought on the subject.

1) *DEI offers little value to pharmacy.* The assumption that pharmacy needs DEI stems from a false narrative being propagated by those who seek to further deepen the influence of DEI and CRT. The profession of pharmacy has been doing quite well at serving the pharmaceutical care needs of patients, regardless of identity group. The past emphasis on "cultural competence" and minority outreach was of considerable value. There was no cause to radically alter pharmacy education or pharmacy practice by creating DEI positions, conducting DEI seminars, including DEI in PharmD curricula, or implementing DEI practices in employee hiring, training and student admissions. Over time, DEI will prove to have been a poor allocation of time, effort, and money.

2) *DEI is doing more harm than good.* The methods of DEI disrupt and rearrange the social order by fomenting and inflaming conflict between identity groups. Advocates of DEI see it as an answer to society's ills, but it is a wolf in sheep's clothing, worsening social division and maligning innocent people. Those who look closely and objectively at the fruits of CRT and DEI will eventually realize that the shaming and intimidating tactics have backfired. The ramifications of hollow, deceitful ideologies will become unmistakably and irrefutably apparent. What remains to be seen is how much damage will be done before people notice that DEI rhetoric does not match DEI outcomes.

3) *Criticism of DEI is strictly forbidden.* DEI was embraced instantly within the world of pharmacy with no appreciable scrutiny. Pharmacy leaders were quick to jump on board and have fiercely defended DEI ever since. Opposing viewpoints are simply not tolerated. Pharmacy literature is one-sided and heavily slanted in favor of DEI. Authors reinforce DEI talking points with lockstep conformity. In fact, it is doubtful that a manuscript expressing criticism of DEI would make it through the peer review process of any major pharmacy journal (except *Christianity & Pharmacy)*. Either there is unanimous support for DEI throughout the profession, or those who have legitimate doubts have chosen to remain silent to avoid a backlash.

Something is amiss—morally and spiritually. It is important for Christian pharmacists to critically evaluate the impact of CRT and DEI on pharmacy and consider the extent to which those values and ideologies correspond to a Christian worldview. Pharmacists of faith should follow their conscience, do what is right in God's eyes, and pray that the truth about CRT and DEI is revealed for all to see. It is currently obscured by false claims, deceptive arguments, and coercive tactics. But truth has an uncanny ability to escape from darkness and make its way into the light. That process is facilitated by those who sincerely seek the truth and are willing to speak it and defend it, so others may see it too.

"See to it that no one takes you captive through hollow and deceptive philosophy, which depends on human tradition

and the basic principles of this world rather than on Christ." (Colossians 2:8, NIV)

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God Has Good Plans For Me

By Katherine Stein

On October 5, 2024, Campbell University sent a mission team to Santo Domingo, Dominican Republic to provide medical assistance to underserved communities. The group consisted of twelve medical students, one pharmacy student, one Masters of Pharmaceutical Sciences (MSPS) student, four providers, and various volunteers of differing backgrounds and skill sets. They traveled from Santo Domingo to different villages that ranged from 15 minutes to 3 hours outside of the city. Over the course of four clinic days, they examined and treated over 650 patients with the help of eight to twelve Spanish and Creole translators.

I was the only pharmacy student who attended the trip as part of my fourth year APPE rotations. I felt God calling me to the pharmacy profession in 2017 after my husband passed away from ALS, a terminal condition connected to his military service. His diagnosis in 2016 piqued my interest in healthcare and after doing some research, I knew I wanted to serve others through pharmacy.

Since I was the only person on the trip with a pharmacy education, I was placed in charge of the pharmacy department. I organized the medication racks, filled prescriptions, provided counseling, performed nightly inventory checks, and collaborated with the providers to determine appropriate treatments based on medication availability. Local churches allowed us to use their buildings for clinics, and patients were often lined up at the door before we arrived each morning.

After the initial set up, the entire team gathered in a circle around the perimeter of the room as a local church pastor led the team in singing praises to God, followed by prayer. The patients were then invited inside to have their vitals taken. They were passed from triage onto a medical team for evaluation where they were assessed for their chief complaint and any secondary complaints, as well as for ophthalmology and osteopathic manipulative medicine (OMM) needs. Clinic workflow varied slightly depending on spacing, but the patients rotated between receiving