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When You Know Better You Do Better: Creating Cultural Safety for Black Patients

by Olivia Riley-States and Renee Crossman

Abstract: Background: Western healthcare is inundated with processes that don't meet the cultural needs of racialized populations or consider non-medical aspects of health and healing. Social structures and power imbalances make it difficult to change these processes. The health experiences of Black people are affected by mistrust, racial microaggressions, and discrimination. To foster health and healing, we must consider the harm done when care is not culturally responsive. Methods: To address the lack of culturally safe healthcare, we completed a quality improvement project to develop an educational workshop about cultural safety with Black patients. The workshop was created using the theoretical lens of relational inquiry and included a literature review, environmental scan, and consultations. The workshop is designed to challenge providers to be self-reflective of their biases while developing an understanding of the health needs of Black patients, especially the African Nova Scotian (ANS) population. Results: The session has been delivered and evaluation feedback indicated positive experiences with some change in knowledge. Participants engaged in difficult discussions about bias and discrimination in their workplaces and themselves. Conclusion: Cultural safety education can positively impact healthcare providers' attitudes. Healthcare is multifaceted for Black people; healthcare providers must understand the intersection of anti-Black racism and health. Rebuilding trust with the Black community, acknowledging harm, and increasing representation in healthcare are necessary to address health disparities for Black people. Healing the relationship between ANS communities and the healthcare system requires critical reflection and targeted actions. Cultural safety education can initiate change.

Keywords: cultural safety; Black patients; African Nova Scotian; education; healthcare

Résumé : Contexte : Les soins de santé occidentaux sont saturés de processus qui ne répondent pas aux besoins culturels des populations racialisées ou qui ne tiennent pas compte des aspects non médicaux de la santé et de la guérison. Les structures sociales et les rapports de pouvoir inégaux compliquent le changement de ces processus. La méfiance, les microagressions raciales et la discrimination ont une incidence sur l'expérience des personnes noires dans le système de la santé. Pour favoriser la santé et la guérison, il faut tenir compte des préjudices causés lorsque les soins ne sont pas culturellement adaptés. Méthodes : Pour remédier au manque de sécurité culturelle dans les soins de santé, nous avons mené un projet d'amélioration de la qualité visant à mettre en place un atelier éducatif sur la sécurité culturelle auprès des patient·e·s noirs. L'atelier s'appuyait sur le cadre théorique de l'enquête relationnelle et comprenait une analyse documentaire, une analyse de l'environnement et des consultations. Il avait pour objectif d'encourager les prestataires de soins à réfléchir à leurs propres préjugés, tout en approfondissant leur compréhension des besoins en santé des patient·e·s noirs, en particulier de la population afro-néo-écossaise. Résultats : La séance a été offerte et les rétroactions découlant de l'évaluation ont fait état d'expériences positives et d'une certaine amélioration des connaissances. Les participant·e·s ont pris part à des discussions difficiles sur les préjugés et la discrimination, tant dans leur milieu de travail qu'à titre personnel. Conclusion : La sensibilisation à la sécurité culturelle peut avoir des retombées positives sur l'attitude des prestataires de soins de santé. Les soins de santé sont multidimensionnels pour les personnes noires; les prestataires de soins de santé doivent comprendre l'intersection entre le racisme envers les personnes noires et la santé. Rebâtir la confiance avec la communauté noire, reconnaître les torts causés et accroître la représentation dans le système de santé sont essentiels pour réduire les inégalités dans le domaine de la santé chez

les personnes noires. Pour restaurer la relation entre les communautés afro-néo-écossaises et le système de santé, une réflexion critique et des mesures ciblées sont nécessaires. La sensibilisation à la sécurité culturelle peut amorcer un changement.

Mots clés : sécurité culturelle; patientes noirs; education; Afro-Néo-Écossaises; soins de santé

Authors:

Olivia Riley-States is a registered nurse working in Quality and Patient Safety, and a PhD student at Dalhousie University, Faculty of Nursing. Her research interests include health equity and cultural safety for African Nova Scotian people in healthcare and behaviour change among healthcare providers.

Renee Crossman is an Assistant Professor at Memorial University of Newfoundland, Faculty of Nursing. Her research program focuses on chronic disease management with a specific focus on diabetes management in real-world settings. Inherent in exploring the "everyday" life with diabetes, Renee also explores blame, shame, and stigma associated with diagnosis and management. Her most recent work focuses on integrating psychosocial and biomedical factors into overall measures of diabetes management success.

Creating Cultural Safety for Black Patients: Introduction

Health equity has become a focus of healthcare leaders, but what does it mean to be healthy? Health and healing are often viewed from a biomedical lens focusing on evidence-based care and medicine, reflecting a Eurocentric perspective. Western medicine is inundated with practices, procedures, and care goals that don't meet the cultural needs of racialized populations or consider essential, non-medical aspects of health and healing. Power imbalances are inherent in healthcare settings and care-based relationships. Social structures and systemic racism make it challenging to change this perspective. Unfortunately, inequities for racialized people are also evident in healthcare leadership. Healthcare leaders must critically analyze the healthcare system and the ongoing harm that Black people experience when accessing it. To meet the needs of the Black population, it is essential to understand their experiences within the healthcare system and the social factors that impact health. The health experience of Black people includes historical and current mistrust of the healthcare system and healthcare providers, as well as other interconnected social systems. Black people also face racial discrimination and microaggressions in the greater community and healthcare environments (Cénat et al. 2022a; PHAC 2020). To foster health and healing, we must acknowledge the harm we cause racialized populations when the available healthcare is not culturally safe or responsive. Continued negative experiences in healthcare can cause mental and physical health symptoms. The PHAC (2020) found that Black women reported their mental health as excellent or very good less frequently than their White counterparts.

Olivia Riley-States who is African Nova Scotian (ANS), has had negative experiences as a healthcare provider and consumer. These experiences created a desire to analyze the healthcare experiences of others in Canada and explore opportunities to improve the health experiences of African Nova Scotians, people of African and/or Caribbean descent, and others who identify as Black, including those of mixed race. Dr. Renee Crossman is an assistant professor who supervised the project, completed as part of the degree requirements for a Master of Science in Nursing. Healthcare leaders can improve health equity and create changes throughout the health system by engaging in professional development and opportunities to learn how to create culturally safe spaces. Informal and formal leaders can also advocate for changes and act as role models. Change does not often come from a place of comfort. To truly create equity in healthcare, we must acknowledge the power imbalances and social structures that drive our practices and be willing to move beyond the Eurocentric views of health and

healing. When we consider healing as an act of communion, we must partner with ANS patients and communities to co-create opportunities for wellness in spaces that reflect their perspectives and experiences.

In this paper, we describe the findings of the literature review, environmental scan, and consultations. The findings include healthcare experiences of Black patients and healthcare providers, including mistrust, racial discrimination and microaggressions, and their mental health impacts. We discuss the need for representation of Black people in healthcare and culturally relevant care, such as Afrocentric practice. Finally, we describe and discuss the development of a workshop to address the adverse health experiences and improve cultural safety in a health system that serves women, children, and their families.

Theoretical Lens

Throughout this project, we were guided by relational inquiry (Doane and Varcoe 2021). Relational inquiry includes hermeneutic phenomenology, pragmatism, and a critical lens. Hermeneutic phenomenology is about lived experiences and is essential to cultural safety (Doane and Varcoe 2021). Additionally, pragmatism means that knowledge is only as good as it is relevant (Doane and Varoe 2021). Therefore, healthcare providers must engage in inquiry as action to determine how culture and lived experiences impact the care encounters of individual patients and families, as well as the Black community as a whole (Doane and Varcoe 2021). We included the application to practice and a locally relevant context to ensure the relevance of the educational workshop. Finally, our critical lens guided our ability to begin to understand and unpack the hierarchies, social structures, and power systems that continue to impact Black patients accessing healthcare and Black healthcare staff.

Methodology

We began by engaging in casual and informal discussions with colleagues to explore the healthcare experiences of Black people locally in Nova Scotia. We learned that Black colleagues had experienced and witnessed microaggressions and discrimination and some lacked trust in the healthcare system despite their roles as healthcare providers. White colleagues also witnessed treatment of Black patients that was different from that of their White counterparts. Based on these discussions, we created a proposal to develop an educational workshop to increase cultural safety for Black patients in the local health system. Due to the limited scope and time frame of the project, the intended population was limited to the Mental Health and Addictions (MHA) program. To develop the background for this workshop, we conducted a literature review, consulted with local key stakeholders, and performed an environmental scan of health institutions in Atlantic Canada to determine if related resources were in use. This was a quality improvement project and, therefore, did not require ethical review board approval. However, we maintained the confidentiality of the consultations and, before completion, received approval from the research department and the director of the MHA program. Additionally, prior to consultations, the project was explained and verbal consent to proceed was obtained.

Literature Review

We searched four databases: Google Scholar, CINAHL, PsychInfo, and Pubmed. The quantitative studies were critically appraised using the PHAC (2014) Critical Appraisal toolkit. Qualitative studies were analyzed using the Critical Appraisal Skills Programme (CASP) checklist (CASP 2017). Twenty-three articles were reviewed. We included North American articles that described the health experiences of Black patients or the impacts of those experiences. From the articles selected, we extracted themes. To explore the use of cultural safety training and modes of delivery, we included articles from several countries that described the implementation or experiences of healthcare providers who participated in education related to cultural safety or cultural competence with any population.

Consultations and Environmental Scan

We consulted with local stakeholders in NS. Throughout this paper, we will refer to the individuals who participated in the consultations as "consultees." The consultees were healthcare staff, both Black and White individuals in the health system and one Black community member. It was essential to consult both Black and White participants to ensure the perspective of Black people was heard while also ensuring the learning needs of the White healthcare providers were met. The consultations consisted of one-hour semi-structured interviews. Finally, we completed an environmental scan of health institutions in Atlantic Canada. We reviewed websites and emailed healthcare network contacts to inquire about educational resources available to healthcare workers on cultural safety and working with Black patients. We thematically analyzed the data from the environmental scan and consultations based on Braun and Clarke (2006). This included six steps: familiarizing ourselves with the data, generating codes, creating themes, reviewing themes, determining the significance of the themes, and reporting the findings (Braun and Clarke 2006).

Findings of the Literature Review, Consultations, and Scan

As we aim to increase cultural safety, we must first understand the underpinnings of the concept and, secondly, acknowledge the factors that influence Black experiences in health. Cultural safety is described as a combination of cultural awareness, sensitivity, and competence (Yaphe, Richer, and Martin 2019). Often, the word *competence* is associated with completion, increasing the perception that providers must know everything about a culture (Lekas, Pahl, and Fuller Lewis 2020). However, cultural competence is grounded in continuous learning, reflection, and understanding of the implications of sociocultural factors (Garneau and Pepin 2015; Kaihlanen, Hietapakka, and Heponiemi 2019). Similarly, cultural humility refers to lifelong learning encompassing openness, acceptance of patients' own expertise, and self-reflection in caring for people from different cultures (Lekas, Pahl, and Fuller Lewis 2020; Prasad et al. 2016)

Historical experiments like Tuskegee, the use of Henrietta Lacks' cells, and current experiences of discrimination foster a lack of trust in the healthcare system for Black people (Cénat et al. 2022a; CDC 2022 Wolinetz et al. 2020). During the 40-year Tuskegee experiment, researchers studied the natural course of syphilis by denying treatment to Black participants and idly standing by while they suffered the horrific outcomes of the disease left untreated (CDC 2022). Commonly known as HeLa cells, Henrietta Lacks' cancer cells were used for years of profitable research without her or her family's knowledge, consent, or compensation, contributing to developments in polio, cancer, and other medical treatments (Wolinetz et al. 2020). Cultural safety is generally applied to working with Indigenous populations despite the importance of applying the principles to all diverse people (Browne et al. 2021; Kaihlenan et al. 2019; Pimental et al. 2022; Yaphe, Richer, and Martin 2019). In 2015, the Truth and Reconciliation Commission of Canada (TRC) called for education to address systemic racism and bias in healthcare, solidifying previous work (TRC 2015). Nonetheless, we found a paucity of literature about education for cultural safety with Black patients. To create culturally safe spaces, healthcare providers must understand the impact of culture on behaviour and show empathy and respect (Prasad et al. 2016). Cultural safety is not a new concept, though there has been a recent increase in uptake in healthcare settings (Browne et al. 2021; Kaihlenan et al. 2019; Pimental et al. 2022; Yaphe, Richer, and Martin 2019). Cultural safety training has been shown to increase awareness of culturally specific issues and barriers to care, increase knowledge and ability to incorporate cultural safety into daily practice, and improve patient interactions (Browne et al. 2021; Kaihlenan et al. 2019; Pimental et al. 2022; Yaphe, Richer, and Martin 2019). Cultural training has been generally well-received, however, some resistance from the dominant race (White) has been found (Browne, Varcoe, and Ward 2021; Erb and Loppie 2023; Micheal et al. 2021). In some studies, at times, White participants have felt attacked during discussions about White privilege and have made racist, harmful comments toward facilitators (Erb and Loppie 2023; Micheal et al. 2021). Facilitators have experienced burnout due to the challenging nature of course delivery and a lack of support from leadership (Erb and Loppie 2023).

For Black patients in Canada, healthcare experiences challenge relationships with health systems and contribute to health disparities such as increased rates of diabetes and lower self-rated mental health than their White counterparts (PHAC 2020). In the following sections, we discuss three contributing factors to these health disparities, including historical and current mistrust, racial discrimination, and racial microaggressions. We also discuss how these factors impact mental health and help-seeking behaviour. Further, we articulate the critical necessity of including Afrocentric practices, the need for increased representation in healthcare, and the challenges in achieving diversity in the healthcare workforce.

Historical and Current Mistrust

Black patients have been subjected to unethical treatment in the health system through experiences such as the Tuskegee experiment (Alsan and Wanamaker 2018; CDC 2022). During this experiment (1932-1972), Black patients were not treated for syphilis even though, during the study, penicillin became the first line of treatment (CDC 2022). Schwei et al. (2014) found that 47% of African American patients reported high institutional trust compared to 61% of White participants when other variables were controlled (OR: 1.93; 95% CI, 1.16–3.23). Black consultees in this study also described a lack of trust in the healthcare system and providers. White consultees described a lack of effort from healthcare providers to develop a trusting relationship with their Black patients and families, resulting in less collaboration in care. Similarly, Boulware et al. (2003) found that Black participants were more likely to be concerned about privacy breaches and harmful experiments being done without patients' knowledge (p=.01). Black patients were less likely to trust both their healthcare providers and health institutions (Boulware et al. 2003; Schwei et al. 2014; Webb Hooper et al. 2019). A lack of trust can increase health disparities; Waldron et al. (2023) found that trust was a barrier to Black patients' help-seeking behaviours for mental illness. All of the White participants in the consultations described a general desire to improve relationships with Black patients and families and the greater Black community. Similarly, Black consultees were open to rebuilding relationships with the healthcare system.

Racial Discrimination

Racial discrimination is inadequately justified differential treatment based on race and disadvantages a racial group (Cénat et al. 2022). Racial discrimination is associated with symptoms of mental illness such as depression, anxiety, and sleep issues, as well as decreased overall mental health (Cénat et al. 2022a; Cénat et al. 2022b; Chan, Pullen Sansfaçon, and Saewyc 2023; Moody et al. 2022; Nguyen et al. 2023). Cénat et al. (2022a) found that 53.1% of Black Canadians aged 15-40 experienced racial discrimination in healthcare, with at least four out of ten participants experiencing racial discrimination every day. Examples include being treated as if they were not intelligent, not being respected, and being threatened (Cénat et al. 2022a). Sacks (2018) found that Black women dressed well when attending healthcare appointments to avoid discrimination and attempted to personally connect with healthcare providers to avoid the race-based assumption that they were unintelligent. There is a social system that maintains the power imbalance in care encounters, which results in Black patients struggling to humanize themselves to avoid discrimination (Sacks 2018). Chan, Pullen Sansfaçon, and Saewyc (2023) found that 35% of Black, Indigenous, and People of Colour (BIPOC) participants experienced racial discrimination compared to 2.1% of White participants.

In NS specifically, Black people are impacted by environmental racism. Environmental racism includes placing toxic waste facilities near Black communities and allowing pollutants in Black communities (MacDonald 2020; Waldron 2018). Examples include the historic Black community of Lincolnville, which has increased cancer rates and is located next to a waste facility; in a 2002 study, 28.5% of Black people in NS lived within 5 km of a waste facility (Waldron 2018). In NS, Black nurses described what was referred to as the "Black tax" or the added weight of being a Black nurse that results from the physical and emotional distress of navigating the racial hierarchies of nursing and healthcare (Jefferies et al. 2022). Black nurses have found it challenging to integrate into nursing due to organizational policies and institutional ideologies that decrease entry into nurs-

ing practice (Jefferies et al. 2022). Despite making efforts to improve the health disparities for Black patients, we are still a long way from achieving health equity.

Racial Microaggressions

Racial microaggressions are subtle verbal, behavioural, or environmental indignities (Nadal et al. 2014). Sometimes, microaggressions are subconscious; however, they may also be intentional (Nadal et al. 2014). Examples from the consultations include Black patients and their families who were treated differently from their White counterparts, despite a similar clinical presentation; care teams made less effort to build relationships and support family involvement in care; and Black patients were discharged earlier and more unwell than White patients with similar disease processes. White healthcare providers stated they had difficulty addressing these concerns because it was sometimes challenging to name and prove, even though they said that a difference was evident to them. Strikingly, Cénat et al. (2022a) found that 49.8% of their study participants were made to feel that their accomplishments were due to preferential treatment based on race, while Williams et al. (2020) found that their study participants experienced hostility due to assumptions of unfair advantages.

Impacts of Historical and Current Mistrust, Racial Discrimination, and Microaggressions

Racial microaggressions and discrimination are negatively associated with mental health symptoms for Black patients, including anxiety, depressive symptoms and sleep problems (Cénat et al. 2022a; Cénat et al. 2022b; Chan, Pullen Sansfaçon, and Saewyc 2023; Moody et al. 2023; Nguyen et al. 2023; Waldron et al. 2023; Washington and Randall 2023). Black patients have vigorously prepared for health appointments due to anxiety about racial discrimination (Washington and Randall 2023). Nguyen et al. (2023) also found that racial discrimination was associated with 12-month and lifetime anxiety levels. Higher levels of everyday discrimination have been associated with increased psychosomatic symptoms (Cénat et al. 2022b). Similarly, higher levels of racial discrimination have been associated with increased depressive symptoms and sleep problems (Hart et al. 2021; Lavner et al. 2022). For BIPOC youth, racial discrimination has been associated with missed physical healthcare needs and previous 12-month suicide attempts (Chan, Pullen Sansfaçon, and Saewyc 2023). Cénat et al. (2022b) found an association between higher levels of experienced racial discrimination and increased psychosomatic symptoms, with headaches being the most prevalent. Mays et al. (2017) found that for Black patients, discrimination was associated with early treatment termination (AOR=13.38, $p<0.05$), with race being the most common reason for discrimination in healthcare. Experiences of racism also indirectly affect provider trust (Pugh et al. 2021). Provider trust mediates the relationship between racism and medication adherence, demonstrating the importance of building trusting relationships with patients and their families (Pugh et al. 2021).

Representation and Afrocentric Practices

Black care providers are hard to find, and Black patients have difficulty finding culturally competent care providers (Waldron 2020; Waldron et al. 2023). Consultees described a lack of diversity in the healthcare workforce; unfortunately, race-based data on the nursing workforce in Canada is not collected (Canadian Nurses Association n.d.). Consultees reported that healthcare providers did not try to build trust and rapport with Black patients and their families. During the consultation process, healthcare providers expressed a desire to learn more about the experiences of Black patients to improve their ability to meet care needs. Healthcare providers expressed a lack of interactions with Black patients because they are not seeking care as often as others, often waiting until their condition becomes an emergency. Every healthcare professional noted differences in the care provided to Black patients that were "difficult to name." The consultees also described experiencing or witnessing racial microaggressions that they were unsure how to address in practice. Organizations have made efforts to increase representation through designated positions; however, it can be a challenging environment for Black care providers when they are the only Black employees in a care area. Black employees have also ex-

perienced racial discrimination when their colleagues feel they did not earn their position; instead, they were given the position because of their race (Cenat et al. 2022a). Although these positions are intended to increase representation, they have the potential to cause further harm. Organizations should intentionally support Black employees and build awareness that they possess the same qualifications as others in the same or similar positions. Organizations should also have strong policies against racial discrimination that outline a clear path for reporting and managing discrimination. Finally, it is essential to ensure that all employees have received education about cultural safety, such as the educational resource we have developed which is discussed in the next section.

Black patients should have access to care that is culturally relevant. Consultees reported that healthcare providers did not make the same effort to collaborate with Black patients and their families as they did with their White counterparts. The health care that Black consultees received did not meet their needs culturally or the needs of Black families that healthcare professional consultees work with. Consultees reported that care practices were based on the views of White people and, therefore, did not relate to the cultural values of Black patients. Afrocentric practices are culturally relevant models of care grounded in Black people's culture, lived experience, and history (Hatcher et al. 2017). The Seven Principles or Nguzo Saba that guide Afrocentricity are from various African cultures and include unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity, and faith (Hatcher et al. 2017). As all Black people are not the same, Afrocentric practices may vary. Although the principles are common in Afrocentric practice, healthcare providers must ensure they do not stereotype Black patients or assume they are all the same. Cultural humility requires ongoing learning and openness to the values and beliefs of others (Prasad et al. 2017). As healthcare leaders, we must maintain this openness and use inquiry as action to ensure we do not perpetuate the feeling for Black patients that they need to act a certain way to be viewed individually and with humanity. Healthcare leaders must be actively anti-racist, recognizing that racism is built into the health system. The burden of dismantling these systems should not be on the equity-deserving group. All patients and families should be engaged in the care process and planning and determine how the principles relate to their lived experience and expectations for care.

White Resistance

Discussions about White privilege can be challenging for some White people, often those who feel they have faced many hardships and had a difficult life that they do not feel was privileged (Browne, Varcoe, and Ward 2021). In an interview with Guardian News (2020), sociologist Robin DiAngelo describes White fragility as defensiveness or hurt feelings that White people develop when their racial views are challenged, including those around White privilege. The behaviours associated with White fragility make it difficult to address and challenge racial biases, even if they are subconscious, because people become fearful of the response (DiAngelo 2011; Guardian News 2020). An example is a White healthcare provider treating a Black patient with less respect than a White patient. The Black patient and other healthcare providers may notice this difference, but they are afraid to say something out of fear that the White healthcare provider will become defensive. Therefore, the disrespect continues with this patient and is accepted. When the next Black patient arrives for care, this behaviour continues. This is how White fragility works to uphold racism (DiAngelo 2011; Guardian News 2020). Together, the findings of the literature review, environmental scan, and consultations formed the foundation of the educational workshop.

Educational Workshop Development

Creating culturally safe environments requires healthcare providers to acknowledge and address the negative experiences Black patients continue to face in health settings. The adverse sequelae from these experiences are not in the past. Mistrust and negative health outcomes are not only historical; they paint a picture of the current healthcare arena for Black patients. Healthcare providers must be intentional about developing an aware-

ness of the experiences that Black patients and their families face outside of healthcare and while accessing services. Critical reflection is essential to cultural humility (Prasad et al. 2016). To address this need, we developed a workshop in cultural safety with Black patients intended for use in the MHA program in a pediatric health system. The workshop draws on the results of the previously described literature review, environmental scan, and consultations. The outline for the eight-module workshop includes an introduction to the course and the following:

1. African Nova Scotian People: A brief history of ANS people, environmental racism, and the history of Africville.

2. The Health Experiences of Black Patients: An overview of the negative experiences Black people have accessing healthcare, including racial discrimination, microaggressions, and historical and current mistrust in the healthcare system.

3. Cultural Safety and Black Patients: An overview of the concepts of cultural safety and how to apply them.

4. Relationship Building and the Black Community: Strategies to build relationships with Black individuals, families, and communities.

5. The Importance of Representation and Afrocentric Practices: An overview of the representation of Black people in healthcare, the principles of Afrocentric practice, and how to apply these principles.

6. Applying Knowledge to Practice through Case Discussions: The unit also discusses White fragility and how it works to uphold racism.

7. Community Resources: Contact information for Black health resources.

While the workshop is intended to increase cultural safety for all Black patients, the intended delivery is in NS; therefore, we have focused on the ANS population. The purpose of the workshop is to increase the knowledge of healthcare providers about the experiences of Black patients and their families and how to create culturally safe and relevant spaces.

Drawing on the principles of Knowles' Adult Learning Theory and Rogers' Diffusion of Innovation Theory, the educational workshop had to be relevant to the potential adopters or participants (Collins 2004; Dearing and Cox 2018). To meet this requirement, we included healthcare staff who were potential adopters in the consultation process to ensure they were engaged and the content met their learning needs. According to Knowles' theory, adult learners need problem-based learning, the opportunity to draw on past experiences, and to understand how the information will help them (Collins 2004). Similarly, drawing on Rogers' theory, potential adopters must understand the relevance of a new innovation and how it will be better than their current practice (Dearing and Cox 2018). Therefore, case studies that explore microaggressions, racial discrimination, and historical mistrust in practice are included to provide an opportunity for participants to apply their knowledge to real situations combining their prior knowledge and what they have learned in the course to a real scenario that has the potential to occur in their care area (Collins 2004; Dearing and Cox 2018).

Results of the Education Workshop

Olivia Riley-States has co-facilitated the educational workshop developed through the quality improvement initiative (as described above) for various groups of healthcare professionals in a healthcare system that services women, children, and their families. Participants included healthcare professionals, such as physicians, social

workers, psychologists, administrative staff, youth care workers, clinical managers, directors, and genetic counsellors. Olivia Riley-States has also facilitated sessions for nursing students. Sessions varied in time from 90 to 180 minutes and covered all eight modules. The sessions included case-based learning, developed specifically for each group and incorporating relevant examples from their practice settings and contexts. Pre and post-tests were completed using an online platform. The results showed some change in knowledge, with an increase in correctly answered multiple-choice questions. Examples of the questions include defining environmental racism and the number of historic ANS communities. The post-session evaluations showed that participants felt the sessions were valuable and that their practices would change based on what they learned. Discussions during sessions revealed that many participants were unaware of the experiences that Black people, especially African Nova Scotians, had faced in the past and continue to face today. Participants were also able to discuss bias within the healthcare system and ways to challenge the system to better serve patients rather than forcing patients to fit within Eurocentric systems. Some participants did have difficulty acknowledging topics such as environmental racism, citing resource-scarce White communities or making comparisons to White experiences. The facilitators worked through this, grounding the discussions in the theoretical perspective of relational inquiry, using inquiry as action to better understand the perspectives of the participants while also maintaining a critical lens of the power imbalances that allow White people to lack understanding of the challenges that Black people face.

Olivia Riley-States continues to facilitate this education to healthcare providers and nursing students in NS. Feedback/data collected is used to improve session content and delivery. The long-term goal is to ensure that cultural safety with ANS patients becomes mandatory for healthcare providers in NS. Olivia Riley-States aims to partner the education department at IWK Health to expand the delivery of the education workshop and collect data through focus groups and interviews, exploring the experiences and changes in attitudes of healthcare workers who have attended a session. Unfortunately, due to a lack of representation of ANS people within the health system, there are barriers to ensuring the content is delivered in-person by an individual with lived experience and, therefore, alternative modes of delivery, such as online, will be explored.

Implications for Healthcare Leadership

The province of NS released the Health Equity Framework in 2023, providing guidance to healthcare systems to increase health equity. Key themes include patient experience, policies, and practices (Department of Health and Wellness 2023). The government of NS and the health systems within it have recognized the disparities in healthcare outcomes, access, and experience. This knowledge has not necessarily reached all healthcare professionals working with the system. It is imperative for healthcare workers to increase their knowledge of the experiences of Black people to provide care that is safe and culturally relevant. Culturally safe spaces can have an immense impact on patient experience.

Unfortunately, not all healthcare providers are culturally competent (Waldron et al. 2023). Healthcare leadership has a responsibility to advocate for educational opportunities to address the lack of cultural safety for Black patients in NS healthcare settings. The Nova Scotia Health Equity Framework underscores the need to advance training in cultural humility and competence, both of which are addressed in this educational session as components of cultural safety (Government of Nova Scotia, 2023). Healthcare educational institutions and professional licensing bodies also are accountable to ensure that entry-level competencies for healthcare providers in NS include the knowledge required to provide care that does not cause harm to African Nova Scotians. Healthcare providers can lead quality improvement initiatives and initiate change on a systems level. Influential leadership will be required to change attitudes and increase awareness of Black patients' health experiences.

Another implication for healthcare leadership is the need to challenge any resistance to discussions about White privilege and the need to dismantle systems that uphold it. Avoiding discussions about race to maintain

the comfort of the dominant race and avoid conflict works to uphold racism by not addressing it (DiAngelo 2011). Using a critical lens allows us to recognize the privilege that healthcare providers of all races hold, although particularly White, and the power imbalance in care relationships. The need to maintain White comfort also creates a barrier to cultural safety for Black patients. There is an assumption that White comfort comes before cultural safety for Black patients, which is evident in the avoidance of race discussions. Healthcare leaders should demonstrate self-awareness and address unacceptable or unethical behaviour, including racism. Healthcare leaders must also analyze their role in upholding hierarchical colonial systems where Black people are not often in leadership or management roles (Beard, Julion, and Waite 2020). Deliberate and intentional action is needed to dismantle hiring systems that only hire White people into leadership positions (Beard, Julion and Waite 2020). Attention must be given to the environments in which healthcare providers are hired to ensure retention of Black providers (Beard, Julion and Waite 2020). Black healthcare providers, such as nurses, must navigate the nursing profession while managing the additional pressure of working within racial hierarchies in nursing and healthcare (Jefferies et al. 2019). It is essential to acknowledge and address these factors as increasing representation in healthcare professions helps to diversify practices and perspectives; seeing a person that looks like them can also increase comfort for racialized patients.

Conclusion

There is growing interest in health equity, and healthcare leaders can improve the quality of care Black patients receive by creating culturally safe healthcare environments. It is imperative to ensure that healthcare systems in Nova Scotia address the harm they cause racialized communities. Health intersects with many other factors, including racial and cultural identity. Healthcare leaders must consider the effects of anti-Black racism throughout all systems and structures in NS and Canada that impact health. Black people face discrimination, microaggressions, and overt expressions of racism in the workplace and hiring processes (PHAC 2020). These factors impact income, which can affect access to healthy foods or transportation. All of the social determinants of health are interconnected and strongly influenced by anti-Black racism. Anti-Black Racism is a determinant of health (PHAC 2020).

The workshop we have developed provides foundational knowledge about Black patients in NS, their health experiences, and how to provide culturally safe care. Black patients' lived experiences and history impact the way they receive care. Factors such as mistrust, experiences of racial discrimination and microaggressions, and a lack of access to Black care providers and culturally relevant healthcare have a negative impact on mental health and decrease help-seeking. We developed an educational resource for a health system that serves women, children, and their families through the lens of relational inquiry, which combines hermeneutic phenomenology, critical reflection, and pragmatism. Healthcare leaders should engage in education that increases their cultural humility and should act as role models for others. Healthcare leaders can actively work toward dismantling systems that uphold racism to reduce health inequities. We are at a critical juncture in health care provision to Black patients. Enhancing this care through increased understanding and application of cultural safety with Black patients is essential. The time is now.

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