Research

"Oh, you're my health care provider?" Recounting the experiences of people of African descent in Nova Scotia pursuing or working in health professions

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Abstract

Background: Increasing, supporting and cultivating diversity in health programs is key to addressing health inequities. We sought to investigate barriers and facilitators that could affect enrolment and success in health professions among people of African descent in Nova Scotia, Canada.

Methods: We conducted semistructured interviews with people who self-identified as being of African descent who resided or grew up in Nova Scotia, who were working in or pursuing a career in a health profession, and who had participated in culturally specific mentorship programs. Semistructured interviews explored participant experiences that shaped their pursuit of a health profession, as a person of African descent. We thematically analyzed transcribed interviews using constructivist grounded theory.

Results: We interviewed 23 participants. Thematic coding showed 4 major themes. The theme of "stand on my shoulders" spoke to the importance of mentorship within the Black community. "Growing through pain" spoke to resilience amidst race-related challenges. "Never the student; ever the teacher" showed the repeated need to educate on issues of race or diversity. The final theme, "change," highlighted next steps, including the need for improvement in curricula, for development of Black faculty and for initiatives that offer support.

Interpretation: We found that mentorship, particularly within the community, was instrumental to promoting feelings of belonging. However, participants described the need for resilience in the face of discrimination during training and in practice in health care professions. Rather than focusing on their education, many had to educate those around them. Increased representation, support programs and updated curricula are needed to promote change.

Building a racially diverse workforce that matches population demographics has been shown to improve health inequity and drive clinical excellence.[1] Racialized health professionals are more likely to embrace working with diverse communities, thus attenuating disparities in access to health services.[2] From a clinical standpoint, concordance between patient and provider racial identity has been linked with higher patient ratings of care[3] and significantly better health outcomes.[4] Therefore, increasing, supporting and cultivating diversity in health programs is key to addressing health inequity.

Acting as a gateway to health professions, postsecondary institutions have increased diversity-conscious policies and efforts.[5,6] Although some interventions have produced a transient increase in the admittance of racialized students, their upstream impact on the diversity of the health workforce is not as well understood.[7] Importantly, factors that are crucial for progress up the academic ladder, such as good academic standing, are more likely to be hindered by experiences of social isolation and alienation for under-represented students.[8] An intervention strategy that directly addresses these factors is the implementation of culturally specific programs within universities to counteract the sense of marginality, invisibility and discomfort associated with being racially underrepresented in an academic institution.[9] Past programs have reported increased confidence and belonging among aspiring health care providers of African descent.[10–13] However, it remains unclear to what extent barriers to meaningful social relations and feeling well-connected persist for racialized health professionals, even while engaging in these programs.

We identified Nova Scotia as an opportune setting to conduct our analysis; despite being home to a large historical community

of people of African Nova Scotian descent and a growing population of immigrants and refugees of African descent,[14] there remains a disparity in representation between the population and health care providers, particularly among those of African descent.[15]

We sought to explore the perspectives and experiences of health professionals of African descent in relation to factors contributing to their sense of belonging within the health professions, which can act as barriers and facilitators to pursuit of these professions.

Methods

Study design

We conducted a qualitative study, which can help uncover narratives within and across populations, using semistructured interviews and thematic coding to describe common experiences among people of African descent who were working in or pursuing a health profession. We thematically analyzed transcribed interviews using constructivist grounded theory.[16]

Theoretical framework

Critical race theory drives our focus on belonging in relation to racial identity. Belonging is the notion of social connection and in particular, engagement with one's own ethnic group.[17] Critical race theory examines inequities, particularly in relation to race and racism, and their impact on individuals and their life chances. We explored several basic tenets of critical race theory, including race as a social construct; racism is endemic; counter-storytelling (i.e., challenging white dominant stories and highlighting the narratives of those who have been marginalized as truths); and whiteness as property, a concept related to "othering" practices by which Black people are seen only in relation to white normativity. Critical race methodology argues that racism is often well disguised in the rhetoric of shared "normative" values and "neutral" principles and practices.[18] Critical race theorists argue that, by not acknowledging race and racism as being connected to skin colour, "colour-blind" racism and postracialism continue to create oppressive living conditions for people of colour. Critical race theory attempts to understand why and how racism has persisted.[19–23]

Participants

We engaged with students in training for health professions and with practising health professionals to map an understanding of the challenges that exist along the pipeline. To ensure that our analysis was nested within culturally specific, diversity-driven initiatives that were already underway, we engaged with those who participated in Promoting Leadership in Health for African Nova Scotians (PLANS) or Imhotep's Legacy Academy (ILA), 2 mentorship programs that were inaugurated at Dalhousie University to increase the number of students of African Nova Scotian descent in health and science programs.

We included self-identified people of African descent who currently reside in or grew up in Nova Scotia, Canada, who are currently working in or actively pursuing a health profession, and who have participated in PLANS or ILA as a mentor or mentee. The rationale for including mentors was driven by findings that culturally specific environments often exert an influence on individuals beyond direct participants, providing both mentees and mentors of the program the opportunity to engage in positive socialization centred around shared racial identity.[9] We defined pursuit of a health profession as being enrolled in the Faculty of Dentistry, the Faculty of Medicine or 1 of the 10 schools or colleges listed under the Faculty of Health at Dalhousie University; we considered licensed health care professionals to be working in a health profession.

Recruitment

We recruited participants via the PLANS and ILA administration, who circulated study invitations via email and social media. The lead researcher also circulated study invitations to known health care professionals of African descent, as well as known students of African descent who were pursuing health care professions, using their connections to ensure that those who were no longer involved in PLANS or ILA were aware of the research. Interested participants would then contact the research assistants (N.E., R.K.) to review eligibility criteria and schedule an interview.

Data collection

We conducted 1-on-1 semistructured interviews with a few exceptions to allow for training of new interviewers. The interviewers were the 2 research assistants (N.E., R.K.) involved in this study. We used an interview guide (Appendix 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.212129/tab-related-content) to ensure consistency and minimize bias in our line of questioning. Questions focused on participants' experiences as people of African descent during their education and training, and in their profession (if applicable), as well as their motivations and influences around pursuing a health profession. After data collection, each interviewee was given a $25 honorarium for their participation in the study.

Data analysis

We recorded interviews, which were then de-identified and transcribed by a third-party individual. Upon request, we returned transcripts to participants for further comment and for correction; we posed follow-up questions when needed. The interview data were analyzed using constructivist grounded theory.[16] First, the 3 authors extracted codes from the data independently, then themes were developed under the primary category of "belonging" once the codes had been compared. All 3 authors were involved in coding; 2 coders completed thematic coding for each interview. We organized data using Microsoft Excel spreadsheets.

Ethics approval

This study was approved by the Research Ethics Board of Dalhousie University.

Results

We initially recruited 23 participants; however, 1 person's occupation did not meet the inclusion criteria as they were interested in pursuing a health profession but were not currently in a relevant

program. Thus, we included 22 participants in the study (Table 1). Each participant completed a 30–60 minute interview virtually or over the phone. Data analysis revealed 4 themes in the experiences of these practising health care professionals and trainees of African descent: "stand on my shoulders," which spoke to the deep importance of mentorship within the Black community; "growing through pain," which spoke to the role of resilience amidst an abundance of challenges; "never the student; ever the teacher," showing the repeated need for students of African descent to assume the role of educator where inequities and issues of diversity are concerned; and "change," which highlighted next steps (Table 2).

Stand on my shoulders

"Stand on my shoulders" recognizes the foundation that has been built by ancestors, families and communities to support the participants to be able to achieve all that they could. Many participants referenced the support of others to help them get through tough times and celebrate their accomplishments. In addition, the participants identified the importance of mentorship in helping with their organization, communication and study habits. One student, commenting on the role and opportunity of having a Black guidance counsellor who helped to guide their process, said, "If it wasn't for [the Black guidance counsellor] who was there to look out for me, I don't know if I would have had that encouragement to believe that that was within my realm of possibilities" (P6). Other students commented on how some Black guidance counsellors provided a safe space.

Participants were encouraged by family and community to pursue postsecondary education despite the financial hardship it could cause for some families. Many expressed the importance of education to get ahead, and that, somehow, the finances would become available. Some participants were the first in their family to graduate from high school, let alone pursue postsecondary education, but still felt supported and celebrated. One participant credited their mom and sister for supporting them through their education: "My mom, she had like 3 or 4 university degrees, so it was really something that me and my sister grew up knowing when you finished high school, you go on to university" (P35). Having Black mentors was key to their success. Participants credited Black guidance counsellors, teachers, mentors and culturally relevant programs for lifting the participants on their shoulders and pushing them forward to success. Programs such as PLANS, ILA and the Black Student Advising Centre at Dalhousie University provided a place for students to be with like-minded individuals. Students described opportunities to meet with other health professional students and learn about their experiences with the application, interview process and other tips to help participants succeed. Participants expressed their thankfulness for workplace opportunities provided to them because of connections made with other Black students and professionals. Many found comfort in a community of people of African descent. Recognizing the challenges of non-Black people and their institutions in understanding experiences of anti-Black racism, participants often leaned on friends and families for comfort, advice and guidance, and not on formalized services. "Stand on my shoulders" reflects the importance of the Black community in supporting health professionals; however, this should not be solely the Black community's responsibility.

Never the student; ever the teacher

Participants carried the double load of taking on an educator-type role throughout their education in the health professions, as well as being a student. Some experienced this from a young age, being explicitly called on by teachers to inform the class about Black culture. Participants noted that, upon attending university,

Table 1: Participants' health profession and level of training

	No. of participants				
Health profession	**Provider** *n* = 9	**Resident or fellow** *n* = 4	**Student** *n* = 6	**Other*** *n* = 2	**Total** *n* = 22
Dentistry	1	0	1	0	3
Health care administration	0	0	1	0	1
Health promotion	0	NA	1	2	3
Medicine	2	3	0	0	5
Nursing	2	0	2	0	4
Occupational therapy	1	0	0	0	1
Pharmacy	0	1	0	0	1
Physical therapy	1	0	0	0	1
Social work	0	0	1	0	1
Speech language pathology	2	0	0	0	2

Note: NA = not applicable.
*"Other" describes participants who have completed schooling in the indicated health field, but are not currently practising in that field.

Table 2 (part 1 of 2): Qualitative data illustrating each of the 4 themes

Theme	Interpretation	Illustrative quote
Stand on my shoulders	Support as a facilitator	If it wasn't for [the Black guidance counsellor] who was there to look out for me I don't know if I would have had that encouragement to believe that that was within my realm of possibilities. (P6)
	Support systems are personal, not institutional	Cliques, clubs and networking connections are a reality and do matter in medicine as in most other professions. If you're not properly mentored and counselled on how to develop your career early on (including after completion of training), it's very easy to miss opportunities because you don't hear about them/get invited, to be unaware of your full potential and underachieve, or be slow to progress to your desired goal. (P26)
	Representation matters	Being around people that look like you and have the same background as you I think is something that's very comforting, it makes you feel safe and it's just a different type of joy. (P32)
Never the student; ever the teacher	Advocating for each other	Knowing the asset that I could be to the community also pushed me as well in that direction and continues to push me in that direction because I know that that's something that's very much needed. (P22)
	Self-advocacy	I always look at the demographics, I always think about well what is this going to look like in a Black person, but no one else really thinks about that. And I don't want to be the person every single time bringing up that one thing. (P12)
	Being an educator, self-advocacy or advocating for each other	You're constantly not only experiencing trauma in terms of seeing the brutalization of Black people and then experiencing your own kind of hardships in terms of life, but then you also have to always just be advocating, so you can never just exist as a Black person. (P14)
	Being an educator	I shouldn't have to teach my teachers how to portray my people. (P32)
	Lack of local opportunities	[University] doesn't offer clinical research bachelor's, like a Bachelor of Science and regulatory affairs and regulatory sciences. So that was not even a program at [university] for me to know of, to have interest. if you don't have like information on this, you'll be confused and that happens a lot in our community. (P29)
Growing through pain	Imposter syndrome	Even when I got in med school I still struggled with confidence against, like I was afraid to raise my hand and speak up in class, ask questions, afraid that I wouldn't sound articulate or smart enough when I talked. Or that they'd catch on, they'd be like oh why [are they] even here, [are they] the diversity admission? Those types of things would cross my mind. (P12)
	Imposter syndrome and microaggressions	I remember, you know, some of my classmates were politically minded and not discussions involving me but around me, about … something like the existence of the seat would have been problematic for this person, so I distinctly remember not engaging in that conversation 'cause I felt insecure. (P3)
	Discrimination as a barrier	I've gotten comments or people not realizing that I'm the [health professional] ... When I went to [province] to practise … . So there were some [health professionals] that wanted me and then there were some that didn't want me and there were some that were advocating for me, but it came down to a race thing. (P23)
	Microaggressions and discrimination as a barrier	Something that's honestly probably still a little triggering for me today, even though like I'm aware of it, is that just like the perception of other people like how I present something. Like I could present an argument the same exact way but it would be taken as … words of aggression and like people got very, very defensive very, very quickly … versus like my [white] peers presenting a similar argument, even if it was something we worked on together, but if [they] presented it, it was almost like palatable for other people. (P34) I think subconsciously that I know that I have to work hard and it's a burden that I carry and I sometimes feel that I can choose not to but it's so hard to get rid of. It's that knowing that if I make a mistake it's just probably going to be dismissed to the fact that I was not as deserving of the spot. Whereas if a white colleague makes the same mistake, it's just a junior trainee. (P11)
	Microaggressions	Had I maybe been more mature at that time, or just had more life experience I might have addressed [the microaggression] in the moment 'cause that was a great learning opportunity for everyone in the room but it's intimidating to do that so it's like, but it stays with you. (P3)
	People expect failure	It was like treacherous going through and I think it's because of a lot of the same concepts were still there. So it's like professors just not believe you were going to succeed, they did not want to identify you as having potential so they [did not want to support] you, me, bring it back to me. (P4)

Table 2 (part 2 of 2): Qualitative data illustrating each of the 4 themes

Theme	Interpretation	Illustrative quote
Change	Representation matters	People who look like you are definitely important obviously because it's so important to see yourself in the spaces as mentors. (P1)
	Representation at the faculty level	I think also there should be some effort or thought to developing Black faculty, because I think opportunities aren't the same across the board for Black faculty and in terms of career advancement. (P26)
	Programs enrolling students of African descent just to meet diversity quotas	It doesn't make you feel good because we're always fighting to be put into the program and you enroll the most, literally if they could enroll half of me I'm sure they would. (P22)
	Positive experience; intentional enrolment	Over the past 3 to 4 years, I think the thing that I've noticed is [the program] has taken an active approach to trying to get more people into the program and I think it's been reflected in the numbers. (P30)
	Positive experience; intentionally seeking feedback	They took interest in the program and kind of did some surveys and asked people how like culturally competent or if they thought some of the classes were and how could they bring more diversity into what we were learning. So I think I did leave that program having diversity being culturally competent in my work, like at the forefront of my mind. (P31)
	Curriculum improvements; education by Black community, for Black community	I would take courses that were supposed to be about diversity and they were taught by white women or like people that would come in and teach us about racism and they would still be talking about things that were like systemically oppressing us and they would contribute to stigma. (P32)
	Support at all levels	It's a tough world for Black faculty and I know people think, oh, once you're faculty, once you're staff, you kind of, you've made it you're out there on a level playing field now you, but it's really it's not, even there, it's not. (P26)
	Need for education around the social determinants of health; fear for Black community	Now [my peers] are all practitioners and they all work in areas not only with Black people but Indigenous communities and they have no, some of them still don't know what the social determinants of health are and they don't understand how it integrates into health outcomes. So that's extremely scary. (P14)
	Curriculum improvements; a hidden curriculum not available to Black students	I think throughout [health professional] school, I feel like I'm given … the basics but there is a hidden curriculum, there's these things that you need to know … and that's why it's so important to me to pass that on. (P6)
	Personal responsibility to bring change (links to invisible tax)	Knowing that I'm one of the few in my program, I do feel a sense of responsibility to bring about some change, at some level. (P11)

they found themselves correcting stereotypes. Participants noted this additional educator role as prominent during postsecondary education; they made attempts to remedy gaps in the curriculum and felt their efforts were not taken seriously. After a series of lectures that presented Black people as having certain stereotyped ailments, 1 participant created case examples that more fully represented the experiences of people of African descent, but their examples were not integrated into case-based learning thereafter. Another participant remarked on an incident with their instructor, during which the participant noted the lack of Black participants as clinical patients despite their distinct dermatological presentations from white patients. Their instructor responded by saying "Well, you need to go talk to your people" (P6). These experiences have been internalized by participants as a perceived additional responsibility to advocate and induce change while maintaining a career in the health professions.

Many participants felt they lacked key information about potential routes for growth, and felt alone in the vastness of university. Students often rallied support from family, community members, community programs or independently to muster resources and develop their knowledge base to make informed decisions about their pathway in health professions. Although support in advising was sometimes an option through some Black student support workers, many students had negative experiences with white advisors, such as guidance counsellors, which set a precedent of mistrust.

Growing through pain

The journey to becoming a health professional was described as being riddled with unique challenges, including imposter syndrome and racial discrimination. Self-doubt or a lack of confidence was not uncommon as many participants reported feeling the need to prove themselves at every turn. Their authority was questioned by patients and their belonging was questioned by peers and faculty alike as many assumed that the Black learner was accepted to their program only to meet a diversity quota. For some participants, these challenges began well before their pursuit of a health profession. Several participants felt underprepared for pursuing postsecondary education. Unlike their peers, several of our interviewees were met with discouragement rather than encouragement from guidance counsellors and teachers

with regard to their interest in a health profession. One participant was even met with shock rather than excitement when sharing the news about being accepted into their program of choice. Furthermore, several participants reported having to navigate microaggressions from faculty, supervisors and, especially, patients throughout their education and in their daily professional lives. Not only were our participants met with these unique and frustrating challenges, but many of them did so being the only person (or one of the only people) of African descent in proximity. The burden of being "the only" was a common experience. Participants described the added pressure when it felt like all eyes were on them. Many of our participants expressed that they felt looming expectations of failure from those around them. Continuously answering questions of their credentials, navigating micro- and macroaggressions in curriculum, and experiencing daily occurrences of racism and remarks of "Oh, you're my health care provider?" spoke to participant resilience.

Change

The issues raised during these interviews led to the question, where do we go from here? A common sentiment among participants was that there was a lack of Black representation at their institution or in the communities in which they grew up. Participants described the need for the development of Black faculty and for support of Black faculty, once participants achieved that level: "It's a tough world for Black faculty and I know people think, oh, once you're staff … you're out there on a level playing field now, but it's really not" (P12). In addition, peers must be sensitive to treatment of their Black colleagues, especially by patients, and educated on how to be allies.

On the other hand, several interviewees also highlighted the importance of supporting young people of African descent. Many felt the duty themselves to be a role model through various avenues including mentorship, advocacy and research. That said, it was also expressed that structured programming for youth of African Nova Scotian and African descent that provided exposure to valuable experiences existed in some regions and should continue to provide access and opportunities.

School curricula are lacking in several areas. Participants found that current curricula do not teach about the contributions of Black people in health, case-based learning tends to exclude the perspectives and experiences of people of African Nova Scotian and African descent, and a hidden curriculum leaves Black students feeling as though they are missing out on important connections that can influence their careers. Finally, participants nearly unanimously expressed that Black health professionals need safe spaces consisting of people they can relate to, empower and be empowered by, and who understand and acknowledge the historical trauma of people of African descent. Some specific suggestions included mental health resources, a social network of Black health professionals and mentorship at all levels. Participants opined that peers and colleagues of people of African descent should not simply stand by as they witness mistreatment, discrimination and belittlement; they should use their voices and privilege to help create safer and more inclusive spaces.

Interpretation

We investigated experiences and feelings of belonging in a sample of health care trainees and providers of African descent in Nova Scotia, Canada, and found 4 major themes. "Stand on my shoulders" spoke to the undeniable role of support and mentorship within and tailored to the Black community in ensuring the safety and comfort of health professionals. "Growing through pain" highlighted common challenges in this population, such as imposter syndrome, having their authority or value questioned, and expectations of failure from those around them. "Never the student; ever the teacher" described the never-ending call for Black people to educate those around them and dismantle stereotypes. Lastly, "change" spoke to the need for improvement in curricula, for development of Black faculty and for initiatives that offer support, acknowledging the unique challenges and experiences of this group as health professionals.

Numerous studies discuss the invisible tax — the perception that members of equity-seeking groups should provide more emotional support or do more diversity work for the institution.[24–26] Some examples highlighted in Breslow's Employment Systems Review[27] include members of equity-seeking groups being asked to provide input on equity, diversity and inclusion projects and issues; unintentionally acting as mentors as someone who had to navigate being a person of colour; and added feelings of stress owing to tokenization. In support of the theme of "never the student; ever the teacher," this shows that Black people at any level are expected to provide diversity education, both formally and informally.

In keeping with the theme of "stand on my shoulders," studies have shown the importance of support, mentorship and representation in increasing the enrolment and comfort of Black people working or training in health professions. For example, a partnership between the Morehouse School of Medicine and Emory University resulted in increased matches of Black residents to emergency medicine programs.[11] Other interventions, such as the Moving Forward Together program, have shown improved self-confidence, a developing sense of belonging and enhanced knowledge for nursing students of African descent.[12] Continued mentorship and instilling a long-term sense of belonging may improve long-term outcomes for Black health professionals.

As was revealed by our theme "growing through pain," people of African descent are met with unique challenges in pursuing health professions. According to the American Association of Medical Colleges, Black or African American people not only remain vastly underrepresented in medical education and medical careers, but also represent the greatest proportion of racial or ethnic groups with significant debt and with plans to practise in underserved areas.[28] Furthermore, the American Speech–Language–Hearing Association[29] reported that only 3.6% of affiliates who identified their race identify as Black or African American in 2020. Similarly, only 2.5% of physical therapists in the American Physical Therapy Association identified as Black in 2019;[30] 4%–11% of occupational therapy departmental members of the American Occupational Therapy Association identified as Black in the 2018–2019 academic year.[31] Race-based

data by profession are not collected in Canada, but in comparison, people of African descent in Nova Scotia represent 3.5% of the population and 1.5% of employees in the Capital District Health Authority.[15] The only health professions that represented people of African descent in proportion to or in greater proportion than the population were nursing and social work.[32,33] Interestingly, in our study, the social work interviewee had the most positive and supportive experience in their training.

In considering the "change" that needs to be implemented, increasing the representation of people of African descent at all levels of health professions and studies; updating curricula to include language, research and images that are inclusive of people of African descent; and implementing social and support groups for health trainees and professionals of African descent across the country should be at the forefront of future initiatives. Relevant to critical race theory, it should be noted that racism is endemic, and the story of people of African descent must be amplified. Future research in this area should seek to further delve into similarities and differences in experiences of those at various levels of their training or career to create a more detailed and holistic image of the challenges and facilitators at each stage. Furthermore, future work should seek to combine both qualitative and quantitative data to better describe and understand the role of intersectionality in these experiences and outcomes.

Limitations

We encountered restrictions to recruitment related to the COVID-19 pandemic and the consequent shortage of in-person events; thus, we were unable to discuss our work at community events, conferences and other social gatherings. The pandemic also resulted in a lack of face-to-face conversations with interviewees, which could have helped develop rapport. We collected qualitative data; however, collection of quantitative data may have provided additional context to our findings. Participants were predominantly from medicine and nursing; however, research is lacking for some of the other health professions (e.g., physical, recreation and occupational therapy; speech–language pathology; audiology; health promotion; pharmacy). Future work should seek to more actively recruit individuals from these understudied groups.

Conclusion

We present an enhanced understanding of the early experiences of anti-Black racism among aspiring and practising health professionals, and their experiences navigating a system that was not designed for them to succeed. The knowledge developed through this research may help to improve health programs for racialized and other vulnerable populations and bring attention to the race-based educational opportunity gap that has been posited in Nova Scotia. Recommendations include increased representation, support programs and updated curricula. Students of African descent have proven their ability, resilience, compassion and willingness to pursue a health profession; it is now up to education and health care institutions to create and maintain a space of belonging and welcoming at all levels so that Black students can continue to excel.

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