3.1: Cultural Safety

It is important to conduct the complete subjective health assessment in a culturally safe manner. Cultural safety refers to the creation of safe spaces for clients to interact with health professionals without judgment, racial reductionism, racialization, or discrimination.

Cultural safety begins with an understanding of dominant cultural structures that serve to exclude persons based on their cultural practices (e.g., beliefs, attire, language) or cultural identity (e.g., ethnicity). For example, dominant structures overtly reproduce exclusion when services are only available in English or French. The system covertly reproduces exclusion when persons are made to feel different, or "other," for their beliefs or views about health.

When seeking cultural health information or any subjective data from a client, it is important to bring a critical lens that acknowledges colonial history, power inequity, and injustice. Consider why you are asking information: is it for racial reductionism or to better understand the client health and illness profile? As described in Table 3.1, today, a critical self-reflective approach is more appropriate, where the health professional questions their own assumptions and challenges stereotypes.

**Self-reflective questions**

<table>
<thead>
<tr>
<th>Question</th>
<th>Rationale</th>
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<tr>
<td>How do I describe my own culture?</td>
<td>Reflecting on how you would respond to a question that you pose to a client is always good practice when self-analyzing. Consider whether you are clear or confused by the question. Dig deep to think about how you define and think about culture. We all practise culture, some being more closely aligned with dominant culture than others. For some, when they align with the dominant culture, they may perceive themselves as not having a culture or not recognizing their own culture. Reflect on what it means to be closely aligned or...</td>
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not with the dominant culture and how this may be perceived in your nursing practice.

Bias becomes problematic when it is acted upon and taken up as legitimacy. Reflecting on how assumptions and bias have influenced your thinking about culture, including primary language, mainstream knowledge, and concepts about health and illness, is important for you to understand how to create culturally safe spaces. In addition to thinking about “setting aside” your bias or assumptions, give thought to the belief system that has contributed to your own biases. What has informed your thinking?

Historically, healthcare was a vehicle for imperial and religious practices, and these legacies have contributed to the context of healthcare today. Western healthcare embodies a belief system predicated on empirics, while elsewhere on the globe other practices are taken up. Recognizing that all clients bring a historical cultural context to their interactions with health professionals is helpful in creating cultural safe spaces.

We all become indoctrinated to language. It is often emblematic of a greater belief system. This indoctrination influences how we practise (e.g., how we refer to people and our interactions with clients). For example, labelling someone by their race or religion reinforces “othering,” where their identity is imposed on them. “Objectified language” refers to language that leads to the objectification of someone (e.g., “the diabetic,” “the alcoholic”) implying that the person is devoid of nuance beyond their pathology and defined by a biomedical system. When thinking about your own language, consider its effects on the client.

**Table 3.1: Creating a culturally safe space**

**Test Yourself**

An interactive or media element has been excluded from this version of the text. You can view it online here: [https://ecampusontario.pressbooks.pub/healthassessment/?p=172](https://ecampusontario.pressbooks.pub/healthassessment/?p=172)