13

Reflection as a Tool of Culturally Safe Practice

Reflection is a powerful tool for learning, development, and growth and is a key component of culturally safe practice. Through reflection, in and on practice, health professionals have an opportunity to examine their interactions with the goal of providing culturally safe and effective care.

This chapter describes reflective practice and how it relates to improving outcomes for all clients. We especially focus on those who experience the greatest disparities and anyone who differs from the dominant culture of the health and human services and providers. Reflection is applied to help health and human service professionals to decolonize and move toward culturally safe practice. Finally, we examine the relevance of this topic to your practice, and the transferability of reflective practice that is regardful in any setting.

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Chapter Objectives

After completing this chapter, you should be able to:

- understand the concept of reflective practice
- identify principles and strategies for reflecting on and within practice
- reflect on the role of individual health professionals in cultural safety at an organizational level
- consider ongoing developments in cultural safety.

Reflection

Reflection on practice is not only a key principle of cultural safety, but also a requisite competency in a number of health and social service professions. There are many strategies that can be used for reflection, from simple sharing of work-related stories with colleagues or friends to more structured approaches such as keeping a professional journal or participating in formal debriefing with colleagues or supervisors.

In a cultural safety context, reflection requires some critique and understanding of one's own culture and how it might influence our interactions with someone who may be of a different cultural background. Importantly when you use reflection as a tool, it should not be limited to simply thinking about and being aware—it then needs application in professional practice.

Do you know your own culture well enough to recognize where it might impact on your interactions with someone? We asked earlier for readers to reflect on how they felt about certain cultural values and norms. You might appreciate that no one has been asked in this book to change what you believe or feel (although that may happen as interactions with those who are not the same as ourselves challenge our existing beliefs and attitudes). What is required to enact cultural safety in practice is to be able to acknowledge what your possible biases, assumptions, stereotypes, or judgments are that we all bring to an encounter. We then need to make sure that these do not harm the person we are providing care or service to through our actions.

Rather than being fearful of making mistakes, or of not knowing something, reflective practice offers the opportunity to stop, consider, and try again if necessary. The point is that cultural values can profoundly influence the judgments, attitudes, and responses to the observed behaviors and practices of people from a differing cultural background and unless you consciously take notice, interactions that are intended to help can have harmful consequences.

What Is Reflective Practice?

Reflective practice is knowing that you do not know it all, and that what you have learned as a student through formal education is not the end of your education but is part of a career-long, even lifelong, process. Through reflection on your practice, acknowledging and exploring your knowledge or lack of knowledge, your discomforts, the ways you interact with others and the strategies you employ to remedy issues, your practice can be improved (Bulman & Shutz, 2004). Bassot (2016) adds that a genuinely reflective approach requires an engagement with your feelings and the need to question your assumptions.

Johns and Freshwater (2005) look at the different layers of reflection, which provides a useful framework for how to engage in reflective practice. These include reflection-on-experience, reflection-in-action, the internal supervisor, reflection-within-the-moment, and mindful practice. These are explained more in Table 13.1.

Activity
Choose an experience you may have had or witnessed where a cultural difference was significant such as gender, ability, ethnicity, or other difference. Use John's (2017) Reflection on Action to draw 'insights that may inform future practice in positive ways'. In other words, what can you learn from your reflection on this experience?

- What principles of cultural safety were absent or evident?
- What could have been done differently?

Table 13.1 Layers of reflection (adapted from Johns, 2017)

Reflection element	Description
Reflection on experience	Reflecting on a situation or experience after the event with the intention of drawing insights that may inform future practice in positive ways
Reflection in action	Pausing within a particular situation or experience in order to make sense and reframe the situation so as to be able to proceed towards desired outcomes
The internal supervisor	Dialoguing with self while in conversation with another in order to make sense
Reflection within the moment	Being aware of thinking, feeling, and responding within the unfolding moment and dialoguing with self to ensure interpretation and responses are congruent to whatever is unfolding. It is having some space in your mind to change your ideas rather than being fixed on certain ideas
Mindful practice	Being aware of self within the unfolding moment with the intention of realizing desirable practice (however 'desirable' is known)

- What potential harms or benefits could you identify from the experience?
- Have you used any of the other layers of reflection? If so, which ones and what insights did you gain?

Schön (1983) discusses the differences between reflection-in-action and reflection-on-action. Reflection-in-action is when we think about what we are doing while we are doing it, whereas reflection-on-action is when we later think about something we did earlier. In terms of practice, reflection-in-action might be noticing while you are doing it that you have had a joke or a moment of connection with a client or that something you said seemed to get a client thinking about an issue. Reflection-on-action might be taking the time, at the end of the day, to review the clients you had, how you handled various situations, the conflicts that arose, and how you managed them. Sometimes it is only

when reflecting back on a situation that you get an 'aha' moment—perhaps in a situation you were not quite sure what a client was trying to say, but later, when reflecting on the situation, it 'clicked': 'aha! *Now* I know what they were trying to say!'.

In terms of cultural safety, the ideas of reflection, as presented by theorists Freire (1972) and Mezirow (1991) are particularly relevant (as cited in McEldowney et al., 2006). Specifically, Freire proposed the idea of 'praxis', which relates to the values that inform practice and considers the function of social justice in health care (McEldowney et al., 2006). Freire also wrote about 'conscientization', or having a consciousness about practice. Mezirow, on the other hand, felt that reflection was much greater than simply thinking about what we are doing, but involves thinking about our relationships, the organizational structures that we work within and the larger social and political influences on what we do.

In terms of health, the complexities can become almost overwhelming. In order to cope, practitioners might just 'do their job' without reflecting on practice, and in the process unfortunately become desensitized to the issues. If we take Mezirow's concept of reflection that involves relationships, organizational structures, and social and political influences, as we have shown throughout this book, health is complex indeed. Relationships may be challenged as professionals learn new ways to communicate and interact with others and organizational structures may further constrain working effectively with clients. For example, access and appropriateness of services may be less than ideal and the health professional may find that there is little they can do to change it. This was demonstrated in research by Grant and Guerin (2018) where they found that child and family health nurses struggled to provide culturally safe care when it conflicted with policies. As a health or human services professional, you may find yourself in politically motivated situations in which reflection may be necessary to examine whether your actions are aiming for cultural safety or perpetuating unsafe service or care for people who differ from yourself.

According to Oelke et al. (2013, p. 369), 'Cultural safety focuses on relationship and social justice with a critical analysis of historical, political and social knowledge of individuals and institutions. Critical reflection is essential to facilitate professionals' discovery of new meaning

or reconstructing existing meaning (Browne et al., 2009) enabling culturally safe care for individuals and communities'. Bassot (2016) also highlights the importance for reflective practice to be 'critical' and underpinned by 'reflexivity'. Being 'critical' in this sense is not about criticizing but being analytical or constructively assessing something. Reflexivity involves mindfulness and being aware of what we think, feel, and how we are acting and being aware of the assumptions that we make (Bassot, 2016). Howatson-Jones (2016) defines reflexivity as 'reflecting on the specifics of situations, as well as the conditions from which they arise, and how we might be implicated in those conditions' (p. 85). Critically reflective practice takes simple reflection a step further to examine power relationships in health care practice and how that power can be misused and can lead to discriminatory and even oppressive practice (Bassot, 2016).

Cultural safety is an ongoing, continually re-assessable aspiration. It's only when the client deems that your care is 'safe' that you can say you have achieved it—for that client, in that situation. The important thing with reflection is that it be used as a tool to improve practice, rather than to criticize anyone for not getting it right every time. It is only through reflection that improvements can be made to practice. Cultural safety is not about feeling terrible for our mistakes and misreading of situations, unless of course those things are done without regard or care for others or done with deliberate discrimination.

Activity

- Think of a situation where you may not have handled something as well as you would have liked. What was the situation? What were the consequences of not getting it right?
- Try to do this activity with a friend and see what their reflections might be.
- There are numerous models for reflection and analysis, and we have only mentioned a few. Find a model that you can use to reflect upon the situation for elements of cultural safety.

While reflective practice can be done at a personal, individual level, developing reflective practice among groups and encouraging reflective practice among supervisors and management is also necessary to fully achieve the benefits possible (Bassot, 2016).

Much of what we have talked about through this book has focused on what professionals might do in practice to ensure cultural safety for their clients. Some of the changes needed may be relatively small and easy to apply and some may seem way beyond 'the pay grade'. But in choosing to enter the 'service' professions, you have probably already recognized that health and social care is more than the individual engagements we have with clients. It's history, politics, social justice, economics, and more.

Cultural safety began when an Indigenous midwifery student stood up in a workshop and challenged the facilitators to consider that health and well-being was more than clinical safety (Ramsden, 2002; Wepa, 2015). That is the power of an individual. That brave question set in motion the development of a transformative way of working that has gone around the world. And like all theories and philosophies, others have since critiqued it, argued about it, embraced it, and refined or adapted it to a range of contexts.

Curtis, et al. (2019) suggest that cultural safety should now be redefined to achieve health equity. They recommend an approach to cultural safety that encompasses the following core principles:

- Be clearly focused on achieving health equity, with measurable progress toward this endpoint;
- Be centered on clarified concepts of cultural safety and critical consciousness rather than narrow based notions of cultural competency;
- Be focused on the application of cultural safety within a healthcare systemic/organizational context in addition to the individual health provider-patient interface;
- Focus on cultural safety activities that extend beyond acquiring knowledge about 'other cultures' and developing appropriate skills and attitudes and move to interventions that acknowledge and address biases and stereotypes;

- Promote the framing of cultural safety as requiring a focus on power relationships and inequities within health care interactions that reflect historical and social dynamics.
- Not be limited to formal training curricula but be aligned across all training/practice environments, systems, structures, and policies (Curtis et al., 2019, p. 14).

Cultural Safety Principles for Practice: An Opportunity to Reflect

Throughout this book, we have presented some of the key principles of cultural safety that we have found to be useful when working with clients. Indeed, the following practice principles are relevant to your practice in general, with anyone who you are working with. We have explored these in some previous chapters, but it is worth revisiting them and considering them in the context of reflective practice.

The first principle, to provide care that is ***regardful*** of culture, directly challenges the status quo of providing care ***regardless*** of culture. Treating all clients the same, regardless of culture, fails to acknowledge the unique needs and issues affecting people who are culturally different, either to one another or to the professional. Users of health or human services should not have to jettison their cultural values and preferred ways of doing things in order to receive care. Of course, there is the option of exercising choice and going to a culturally specific service. However, all citizens are entitled to an equal opportunity to achieve optimal health; this does not mean necessarily by sameness.

Critical Thinking
How do you feel now about the idea of treating people the same? Has anything changed for you after exploring this notion of being regardful or different rather than regardless? If you remain unconvinced by the arguments in this book, write down your reasons. Provide rationales for your answers, not your opinion or feelings.

The second principle, to *engage in dialogue*, sounds like a simple thing to do, but even where there is no language barrier, cultural and other communication barriers make this challenging in practice.

Scenario

A single father has been in small rural hospital for a few days with his sick child. He often leaves during the day and the child is naturally distressed and cries for her father. Another mother sharing the room is looking after her sick child. She sits by the bed all day and tries to organize her family through phone calls and through visitors coming to see the mother and child. Meals are served in the afternoon and by the time the father comes back his meal has been taken away.

'No, you're too late. You missed your dinner' says the nurse, when he asked if there was any food left. Later in the evening the same nurse quietly asks the woman sharing the room if she would like a cup of coffee and something more to eat. They chat cheerfully about how early the meals are served. The nurse then suggests that the mom take a break and go home for a few hours, reassuring her that the child will be ok. The father on the other side of the curtain is not offered any such support.

- What might be behind these differing responses from the health professional?
- What assumptions have been made?
- Why was there no apparent dialogue with the father who left during the day?
- Why does one parent elicit empathy and compassion and the other does not?
- How aware or unaware might each be of the dynamics being played out?
- Describe the power relationships in this scenario.
- What questions and issues would you like to have discussed with both parents?
- Turn your reflection to the organization. What responsibility does the health service have for the experience of the client who kept leaving?
- How might the environment have been made more culturally safe? What supports, personnel or resources would have been helpful in the situation described?

The third principle of culturally safe practice is to be mindful of *whose values are being valued*. Generally, our values are unstated or assumed, and we do not tend to think about our values until they have been challenged. However, our values can have significant impacts on client care, so much so that competency standards include a number of references to values. They also ensure that values are not imposed on clients and that client values if in conflict with those of the health professional, do not compromise the client's care and are respected. Values, however, are an abstract concept and there can be a very fine line between respecting another's values and compromising their care. Interpretation of values is not easy, which is also why reflection is important. For example, you might know someone, or maybe you yourself, who does not put high value on having an immaculately clean and tidy house. Nevertheless, at what point is an unclean or untidy house a health hazard? Of course, it can become a health risk, but there are many degrees to such a judgment. This is a good example of a value, how it can be imposed and how a value can be expressed in different ways.

A child not wearing shoes might, in some settings, be interpreted as not being cared for properly or even neglected. However, in other contexts, not wearing shoes might be perfectly acceptable. We are not suggesting here that 'differing values' should be an excuse for inaction when that may well be called for. There can be a very fine line between value differences and neglect. However, in such an instance, it is critical to engage the relevant people themselves in establishing whether something is culturally appropriate or whether it is an example of dysfunction.

Another principle of cultural safety is to *examine power* in practice and work to minimize inequalities between yourself and the clients. The power of the professional is often not acknowledged in practice, but it can affect care and practice, both on the part of the health professional as well as on the part of the client. For example, a professional has power in terms of medical knowledge, and power in terms of negotiating treatments and services. You as an individual may not feel powerful, but relative to your clients or other workers in your team, you can be more or less powerful at different points.

Page and Meerabeau (cited in Elliot, 2004) believe that if the reflector perceives themselves to be in a powerless position to orchestrate changes or suffers from professional apathy, learning and practice are unlikely to be advanced. Thus, successful reflection is as much about the attitude of the clinician as the topic or theme being explored.

Scenario

A man was discussing treatment options for his failing kidneys. He was a non-drinker and because he had young children, he naturally wanted to be around for them. They discussed dialysis which would have been really difficult as he came from a rural area and would have had to relocate to access services. He asked his doctor about the potential of a kidney transplant, but the doctor advised that this was not an option. Other staff who were present later asked the doctor what the barriers were to this client being considered for a transplant. They knew the man to be strongly committed to his treatment. They were told that the client was 'unlikely to comply with the medication regime' and was unlikely to be able to comply with the strict transplant requirements.

- It's too obvious to ask who here had the power, but what message does this send about the value of this man to society?
- What role might the other staff have in advocating for this patient?
- Who should have been involved in the decision-making?

Revisit the scenario above about the two parents. What values were being privileged in the scenario? What does a 'good' parent do when their child is sick? They often stay vigilant by the child's side, stoically resisting all offers to leave, because the core value for being a 'good parent' for some people is demonstrated in this way. For the single father that left during the day, his core values may have caused him to choose to leave the child in the capable hands of the hospital staff while they did the 'good parent' thing of attending to the rest of the family's needs.

Instead, assumptions are made by all concerned, including the clients, without actually engaging in dialogue. Judgments, lack of empathy, and misuse of power—either consciously or unconsciously—ensure that the experience of health care is very different for both families.

You might have realized by now that in most of the scenarios presented in this text, we have frequently not specified race or ethnicity, gender,

age, or other possible cultural identities. Did you notice any previously unrealized assumptions, stereotypes, or biases of your own that led you to apply a racial or ethnic, gender, age, sexual orientation, or other backgrounds to the characters while thinking through the questions? Were any receptionists male in your vision of these scenarios? If not, why not? Being able to reflect is the most effective way to check your assumptions and possible biases.

The principle that *process is more important than outcomes* is an interesting one. Research shows that good process results in better outcomes, but if we focus on outcomes exclusively, the process is often compromised, and the outcomes are poorer. Do you think that clients are more interested in having a provider who is highly knowledgeable or one who cares about them? We would hope to provide both, but some research shows that clients are more interested in being cared about (Frankel & Stein, 1999). This links back to the discussion above on empathy. It does not take much longer to show compassion and concern to a client, but it can make a big difference to the outcomes of the care. The process of care also involves more than just any individual health professional along the path.

Think about access to care and services—can clients access the care or services readily? Are there transport or other costs associated with accessing the care that need to be considered? If medication has been prescribed, have any barriers to accessing the medication or taking it been explored? For example, has the cost of the medication been considered and addressed? If the medication has to be refrigerated or if it needs to be taken at certain times (such as with food), has this been addressed? What about the reception staff—have they done all that they could do to reduce barriers to accessing the service? Who should receive cultural safety training in health services?

You might intend to provide culturally safe care for your client but if their experience is an unsafe one at the front door, your efforts could be thwarted. Curtis et al. (2019), suggest widening the cultural safety training for staff and curricula to ensure organizations and systems are prepared for the job.

We discussed racism and discrimination and noted that a key element here is not what someone's intentions might be, but rather, how someone might experience a situation or an interaction. As a culturally safe professional, reflect on policies, practices, and procedures in your workplace as well as your own interactions. Can you identify discriminatory practices in your workplace or somewhere you have attended? How might it be changed to reduce that possibility?

Become more aware of how your own interactions and the workplace environment can be colonizing and consider the ways that you might begin to decolonize your practice. Colonizing practices can be revealed through how language is used or the assumptions that are made. What behaviors could contribute to continuing to colonize?

In summary, these principles are to:

- provide care that is ***regardful*** of culture.
- engage in *dialogue*—talk.
- ***ask*** what your clients want and ***how*** they want you to provide the services they want.
- be mindful of ***whose values*** are being valued.
- reflect on your own ***power and privilege*** and role in empowering others.
- ***process*** is more important than outcomes.
- continually ask yourself, 'are my ***actions empowering*** or disempowering?'
- examine the context for possible elements of *racism* or *discrimination.*
- *decolonize* your practice through examining language, assumptions, and behaviors.

There may be other principles you can add to the list above. However, even with just these few, there is a real opportunity to enhance the care experiences of culturally diverse Americans. Considering the enormous challenges of the current health and social status of sectors of our community, the role of health and human services professionals is an immensely important one.

Practice Strategies

We have discussed some practice principles and will now explore some practice strategies. For example, strengthening resilience encourages professionals to look for strengths and work with those. If a client needs to be more active, financial issues need to be considered as well as the environment that the person lives in. What interests and opportunities does the client have that can be used to develop an interest in and capacity to be more physically active?

'Deep listening' is a practice strategy that can build rapport and create an atmosphere that encourages communication. In the above example, a professional might respond by saying, 'That must be very hard', thereby acknowledging what was said, but then, 'how are you doing with that?' (thereby providing the opportunity for the client to elaborate).

De-Othering is the opposite of 'othering'. 'Othering' is when people treat 'others' who are different in some way from themselves as if they were in a different category. This is an 'I am this' and 'you are that' way of thinking and treating people. How do we know if we are 'othering'? We see evidence of 'othering' when people say things like, 'we don't do it that way, ***we*** do it like this', or 'how do ***you people*** …', '*they* don't look after their health…' '*they* don't care…' Who are 'we' and who are 'you people' or 'them'? Look critically at the assumptions that are made in comments like these. De-Othering is about looking at similarities, as humans, rather than looking at differences or areas of separation between people or groups of people.

When we reflect on how the specific workplace that we work in, as well as the larger systems of health care and human services, influences how we work, what works, and what does not work, then we are in a better position to advocate for change. This can include building environments for change and being a part of that. It may include looking at the educational or employment influences on health and illness, not just at illness as something that needs to be diagnosed and treated.

Critical Thinking

What is something that you could put into practice from what you have learned in this book?

What have you learned about yourself while reflecting on some of the content of this book? Were there aspects that 'pushed your buttons' or possibly shifted a long-held belief?

What if anything, might you do to enact cultural safety at a personal and organizational level?

The work of academics, researchers, and practitioners in taking cultural safety further is ongoing and there have been refinements and development of ideas and principles as we reflect on how this concept plays out in practice. Curtis et al. (2019) have turned their attention to the organizational level with their latest iteration of a cultural safety definition:

> Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment.

In operationalizing this approach to cultural safety, organizations (health professional training bodies, health care organizations, etc.) should begin with a self-review of the extent to which they meet expectations of cultural safety at a systemic and organizational level and identify an action plan for development. The following steps should also be

considered by organizations and regulators to take a more comprehensive approach to cultural safety:

- Mandate evidence of engagement and transformation in cultural safety activities as a part of vocational training and professional development;
- Include evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and ongoing certification;
- Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes);
- Require cultural safety training and performance monitoring for staff, supervisors, and assessors;
- Acknowledge that cultural safety is an independent requirement that relates to, but is not restricted to, expectations for competency in ethnic or Indigenous health (Curtis et al., 2019).

Notice that in this definition, the emphasis has shifted from the individual to a shared responsibility with the health services to also examine their biases, attitudes, and barriers and to have a measurable outcome. But what are the structural barriers? Workforces have not really been discussed so far. How can the makeup of the workforce help or hinder the cultural safety of an organization? One of the common features of a culturally safe organization for clients is the opportunity to see someone of their own cultural background (age, gender, ability, ethnicity, etc.) in the service environment. How diverse then is the professional environment in your area? You might start looking to see how representative the workforce is of the people who access it. And if it is representative, in that there is diversity, where are these staff members in the organization? Are they at the client interface or are they in less visible roles, are they across all levels of the organization or only some? What will this say about the cultural safety of the organization? Racial or ethnic, gender and other representation have been addressed through certain strategies such as affirmative action, but that, too, has not been without controversy.

Making It Local

What other strategies and structural barriers need to be addressed to ensure an inclusive workforce? Look at each aspect of the recommendations and apply them to your own local health service or one you are familiar with. How does it measure up? If not, what would need to happen to make the organization culturally safe?

There has been some controversy in countries that have chosen to take up cultural safety as an approach to healthcare and resistance has come in many forms. If professionals talk about history and colonization they may be told, 'the past is the past; get over it'. If some people suggest that the 'helping professions' might actually harm their patients by continuing colonizing practices, they may be told that this perspective is 'outrageous'. If you were to tell a worker who is themselves struggling to put food on the table as bills mount up that they are privileged in their professional setting and that they have power, you may find that they are not very receptive to this point of view. Just like the debate that Black Lives Matter does not mean that other lives don't matter, cultural safety's focus on the need to decolonize, to examine and shift power, and to become aware of relative privilege, does not mean both cannot be true. Remember the diunital thinking we discussed earlier. You can be both powerless *and* powerful, depending on context. You can be oppressed, *and* you can also be a colonizer. You can be struggling, *and* you can be privileged. Cultural safety simply asks you to be regardful of these aspects of culture that have the potential to impact negatively on those you provide services or care to and, if anything, having experiences of both can give you something to draw upon to relate to and empathize with your clients.

Cultural Safety of Health and Human Service Professionals

We have talked almost exclusively about cultural safety for clients and communities, but we have not talked about what it means for health

and human service professionals and other staff. Cultural safety is not and should not be a 'one-way street'. Those who provide services, you and your colleagues are also entitled to feel culturally safe in your workplace. You are no less entitled to provide service that does not demean or discriminate against you in the process. What has been our collective experience is that when you are able to provide culturally safe care, your safety, job satisfaction, and sense of achievement can be greater than anticipated.

Conclusion

A nation is only as strong as its most vulnerable populations. If any group is left behind on the basis of an aspect of who they are, (race, ethnicity, gender, sexuality, age, disability, religion, age, or any perceived difference) then that is a failure of the principles on which our country is founded. Health disparities and cultural issues are worthy of our collective attention by virtue of current failures to adequately meet the needs of various populations. As health and social service professionals, we can continue down a path that has seen certain members of the community excluded from the right to achieve optimal health, or we can use our practice to make a difference. If the experience of health and social care of one person is improved through a conscious effort to ensure cultural safety, then we will have achieved something significant.

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