

Cultural competency/safety in healthcare

There is current interest in cultural safety and cultural competence in tertiary institutions the world over. We need to learn it, teach it, and practice it. While this is true across the sector, my paper just focuses on teaching, learning, and assessing it in medical and health sciences. But what is cultural safety? Is it different from cultural competence? In the paper I discuss the historically-based answers to these questions. Essentially, cultural safety is what the person experiences and cultural competence is what we do to promote that feeling in others of cultural safety. However, just as the paper was going to print some of my colleagues (Curtis et al., 2019) published a different paper where they proposed a new definition of cultural safety, which incorporates elements of cultural competence within it. So, the trendy term to use these days in healthcare is cultural safety and Curtis et al.'s definition is a great one to use.

That aside, in my paper I suggest that we do different things to promote cultural competence/safety and that all these things help but they are not created equal. Some of the stuff we do is harder or more challenging than other stuff. In this paper I talk about this difficulty using analogy. I suggest if we think about cultural competence/safety as though its an ocean we could see the strategies we use as sitting within one of three zones: surface competency zone, bias twilight zone, and the confronting midnight zone.

The surface competency zone is the relatively easy stuff such as learning about a culture (increasing cultural awareness), ensuring interpreters are available when needed, or creating a designated prayer space in each hospital; essentially demonstrating value and respect for people.

The bias twilight zone is where people engage in critical reflection on their inherent/unconscious biases, and how such biases inform their thoughts and practices. The focus here is on individual people. Increasing self-awareness about biases and practice is a good step towards increasing responsiveness at an individual level.

The confronting midnight zone is where people engage in critical consciousness and self-awareness. Here they look beyond their biases to interrogate their power and positionality in society (their own privileges and centralisation). This attention is coupled with a commitment to social justice, cultural responsiveness, and to working within their means to reduce health disparities.

Our efforts at each of these levels help to create an overall environment in which we all feel culturally safe. Many drops fill an ocean. But the deeper zones are challenging and this cannot be understated. If we make structural changes it will be hard and not just for a little while and not just for a few people. Structural changes are **necessary to achieving equity**. The confronting midnight zone is the tough stuff and it is also where action will reap the biggest rewards.

Finally, the paper looks at how cultural competence/safety has been assessed in individual

students in medicine and health sciences around the world. The first two zones of competency/safety can be assessed at an individual level. With the third zone assessment gets a whole lot trickier and I don't think we are there yet.

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[Three zones of cultural competency: surface competency, bias twilight, and the confronting midnight zone](#)

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