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Editorial

Safe enough? Rethinking the concept of cultural safety in healthcare and training

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Summary

Refining the cultural safety concept to include an acknowledgement of both the discomfort inherent in training and care and the time needed to overcome multiple layers of oppression may partially buffer the feelings of failure or fraud that often arise from unrealistic expectations regarding equity, diversity and inclusion policies.

Keywords

Cultural safety; healthcare; training; policies; equity.

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First formulated to address structural and historical violence in interactions between Māori patients and non-Māori clinicians, cultural safety emphasises the importance of explicit attention to historical and ongoing social factors that make the clinical encounter unsafe.[1] It was coined in reaction to the systemic limits of the concept of cultural competence, which refers to the process of adapting healthcare to individuals and communities of different sociocultural background.

Recently in the UK it has become a key concept to advance anti-oppression and anti-racist practices in healthcare[2] and it has been operationalised and widely applied in equality, diversity and inclusion (EDI) policies through training and healthcare guidelines in the UK, Europe and North America.

Research on the effectiveness of these iterations of the concept remains scarce. Preliminary observations on its application in different fields support its usefulness but also highlight the risk of becoming a contested, rejected and disvalued ideological stance, often characterised as 'woke'.

For those who advocate social justice, these criticisms certainly reflect a resistance to social change and the desire to maintain past privileges, whereas for patients who identify as Black, indigenous or racialised, they convey a lack of willingness to improve the care they receive in hospitals and other health services. Before glossing over the controversy and its associated discontent, it is worth closely examining the implicit assumptions in the ways the concept cultural safety is understood and applied.

Acknowledging the legitimacy of distrust and anger

Safety in healthcare, and in particular in psychiatric services, is not a given, especially for those who belong to racial, ethnic, religious or gender minorities. In an increasingly polarised world, acknowledging the existing inequities and legitimising the subsequent distrust is an essential starting point for clinical alliance.[1] By introducing present social suffering and the legacy of colonialism into caregiver–patient relationships, the concept of cultural safety becomes a tool to acknowledge the multiple levels of direct, covert and structural oppression that may interfere with care. Such collective construction of entitlement and the subsequent awareness of power imbalances may serve to prevent an individualised and often pathologised clinical interpretation of perceived avoidance, anger and distrust – which may be resistance strategies to survive ongoing discrimination. However, the notion of cultural safety may elicit idealised expectations on the side of the caretaker ('I can regain a benevolent stance') and of the patient or trainee ('I should always feel safe'). The frequent disappointment associated with idealisation processes may fuel the grievances and the feelings of misunderstanding on all sides.

Safety, discomfort and power in healthcare and in training

Human encounters – their verbal and non-verbal exchanges – have always been sources of both comfort and distress. Discomfort in learning and healing processes is almost inevitable, and potentially necessary in some form. Learning requires continuous critical questioning of one's assumptions and performance, a process that while rewarding is also destabilising and often painful. Receiving mental healthcare, even when no cultural gap is assumed, often sets the scene for a power imbalance between the carer and the patient. Partly tied to the perceived expertise preceding the establishment of trust, this may nonetheless remain uncomfortable.

Patient-centred care introduces a possible double bind: on one hand clinicians are requested to listen to the patient and take their identity and subjectivity into account, while on the other hand they are trained and expected to apply evidence-based knowledge adhering to standardised protocols, implicitly considered as having a universal value. These two predicaments may not always be compatible and the resulting negotiation in shared decision-making often provokes tensions and distress, in both the patients and the clinicians. Thus, if cultural safety is a goal we aim for and

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which requires training, it may be important to foreground the diversity of outcomes of this well-intentioned process of change, which is by no means easy to implement.

Idealising reparation or mourning perfect benevolence?

Re-establishing trust between oppressed communities and mainstream services is a time-demanding process that cannot happen rapidly. EDI policies are a needed milestone, to advance institutional agendas of change, but they may elicit disappointments as hidden agendas persist.[3] For all politically correct discursive strategies, communities may be left with the impression that nothing is changing given the slow pace of transforming practices, but also because the ideal proposed is formulated to restore the benevolence myth of our societies, shattered by the admission of structural racism. When viewed as an ultimately attainable goal, the concept of cultural safety may elicit false hopes and be disqualified as negating the inherent discomfort associated with legacies of oppression, training and caring relationships. Against this backdrop, what are possible avenues to preserve the usefulness and transformative potential of the concept of cultural safety while acknowledging its limits?

Winnicott,[4] paediatrician and psychoanalyst, coined the expression 'good enough' to express the realistic expectations mothers should have. A good mother is the 'good enough' mother, who by failing tolerably prepares her child for the imperfect world. We propose that in its practical application the concept of cultural safety should aim towards the 'safe enough' space. 'Safe enough' conveys the limits of our capacity when reassuring the trainee or patient. In addition, it acknowledges the fact that distress and discomfort in care relationships cannot (and probably should not) always be mitigated. Furthermore, the expression 'safe enough' sets the ground for the balancing act needed to provide care or training, to heal or to learn. Such use of the concept introduces the idea that perfect benevolence should be mourned, that individual and institutional efforts, although essential, cannot rapidly overturn centuries of oppression and that we must accept the political responsibility of our collective history.[5] It also introduces the idea that we inevitably do harm in some way when we teach and when we provide care, even if for an ultimate good. Individual, institutional and systemic efforts to create a 'safe enough' space in mental healthcare should continue in the years and decades to come and be accompanied by profound social changes at every level to entangle the legacies of oppression.

Implications for training and policies

Framing EDI policies and procedures as time-demanding processes that will repeatedly re-enact the frustration and tensions they are intended to address, on both the majority and the minority side, may facilitate dealing with the inevitable discontent they generate on both sides. Like reconciliation processes, they are only a small step in the urgently needed social reparation. A concrete way to address this would be to ensure that EDI officers have strong mediation skills and that critical feedback loops are built into implementation practices to respond to procedural obstacles. Spaces for open dialogue and dissent may facilitate exchanges between different perspectives rather than imposing a politically correct orthodoxy (a practice often observed in medical fields).

Refining cultural safety conceptually and in training to include an analysis of the multiple and at times subtle levels of discomfort inherent in training and care may allow us to redefine the goals to be attained. Culturally safe practices may be more about having the capacity to recognise and acknowledge discomfort, taking a culturally humble stance and having an open dialogue on what contributes to trust and common engagement, rather than aiming to eliminate distrust and resistance. Trust is central for the therapeutic alliance and largely relies on experiences of authenticity, which is enhanced by openness and admission of weaknesses. Although these are often interpreted as personal characteristics of the clinician, the encounter of collective histories and fragmented representations of the Other may, if not recognised, undermine the wish for an honest connection. Distrust and resistance should be expected, tolerated and worked with as part of protective strategies in the face of layered histories of oppression and marginalisation. This realignment with more attainable goals may partially buffer the feelings of failure or fraud that can arise from unrealistic expectations that drive one to negate discomfort before truly engaging with it.

Finally, fostering a social debate about cultural safety may invite us to revisit the iconic images that we perpetuate about education and psychiatry and to examine the role that these ideal representations might play in the present social polarisation in training and mental healthcare practices.

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Data availability

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Authors contributions

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