New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

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Chief Executive
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By email: SConsultation@mcnz.org.nz

Cultural Competence, Partnership and Health Equity

Dear Joan

Thank you for inviting the New Zealand Medical Association (NZMA) to provide feedback on the above consultation. As you know, the NZMA is New Zealand's largest medical organisation, with more than 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Board and Advisory Councils.

We congratulate the Medical Council for the work it has done in these important areas. We note that the review of Council's existing statements on cultural competence and best practices when providing care to Māori patients and their whānau has been conducted in partnership with Te ORA and guided by expert advisory and governance groups. We note that both these documents have been revised to reflect current guidance and to provide greater clarity on the required standards of cultural competence and provision of culturally-safe care.

Draft Statement on cultural competence and the provision of culturally-safe care

Council's statement has prompted a robust discussion on the use of the terms cultural competence and cultural safety, including their relative merits and limitations. There are some concerns that cultural 'competence' could be reduced to a kind of mechanistic 'tick box' sign off process. While there is obviously a need for some basic factual background awareness, knowledge and understanding of Māori and other cultures, it is important that the cultural knowledge obtained by a doctor leads to genuine understanding, empathy, humility, sensitivity and respect with regard to the patient, family or whānau in front of them. In this regard, it is as much about the culture, values and attitudes that prevail among doctors themselves. We agree that the first step in this process is for doctors to be better educated about the historical and cultural factors shaping health inequities and to gain more self awareness of their own hidden biases and prejudice.

Likewise, there are some concerns that cultural 'safety' could conjure the impression that this can be achieved by some kind of checklist when what is necessary is to foster a culture that is characterised by genuine cultural sensitivity and equal respect for all patients with no room for

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discrimination, prejudice or judgement. In other clinical domains, concepts of safety tend to be applied purely in terms of harm avoidance and simple dichotomous notions of 'safe' versus 'unsafe' which do not do justice to the complexity of the human interactions and relations Council is seeking to describe. While there is no obvious alternative term, the focus should be on capturing the importance of the patient having positive and empowering interactions with doctors and other health professionals. Values and culture of the patient should be put at the centre of the doctor-patient interaction / relationship. As such, we suggest that 'patient cultural empowerment' may better capture what we should be aiming for from the patient's standpoint.

The above concerns about terminology notwithstanding, we believe that it is useful for the statement to address both cultural safety and cultural competence. While the statement explains that cultural safety better highlights the power relationships between participants in a health care interaction and focuses on the experiences of the patient to define and improve the quality of care, it may be useful to further clarify the differences between cultural competence and cultural safety. Professionals' and professions' cultural competence is a necessary but, in itself, insufficient part of patients' cultural safety and empowerment. We suggest referencing a seminal work on this area that, though old, is still helpful in terms of clarifying the wording and definitions of cultural safety and cultural competence.[1]

We believe that it would be useful for the statement to explicitly acknowledge that culture and ethnicity are important health determinants in themselves. Furthermore, rather than establish and maintain a degree of 'competency', there is a view that practitioners should actively seek excellence in the provision of culturally safe health care. This stems from the fact that in human resources discourse, 'competent' is often equated to a bare minimum level or standard while the terms 'proficient' and 'excellent' are used to denote progressively higher levels of capability.

We agree with the standards that are proposed in paragraph 15. With respect to the standards that are grouped under awareness and knowledge, we suggest that self-reflection should be encouraged in a group setting if possible. We also suggest that the document as a whole would be enhanced by incorporating descriptions of the concepts of Manaakitanga, Whanaungatanga and Tikanga.

Draft Statement on achieving best health outcomes for Māori: a resource

We consider the Draft Statement on achieving best health outcomes for Māori to be an excellent resource. We assume question 4 in the consultation refers to paragraph 24, not paragraph 27. Currently, point 24 reads as though only doctors as individuals with just their own associated healthcare provider organisations have a role in supporting Māori health equity. We recommend that wider professional bodies be added to point 24 such that organisations such as the NZMA, Colleges, the Medical Council and professional associations / societies also have a role in supporting Māori health equity. Suggested amended wording could be along the following lines:

> *"Doctors and their <u>associated professional bodies</u> and healthcare organisations can support Māori health equity by:"*

We suggest the addition of two further points under paragraph 24 to reflect the importance of engaging and supporting Māori at the very outset of policy / strategy development. Suggested wording could be along the following lines:

[1] Durie M. Cultural competence and medical practice in New Zealand. Paper presented to the Australian and New Zealand Boards and Councils Conference, Wellington, New Zealand, November 2001. Available from https://bit.ly/2X35Lyy

f. engaging Māori health organisations, governance groups and representative committees for input into public policy changes and development that may affect Māori

g. supporting the efforts of Māori health organisations, governance groups and representative committees with public policy development that may affect Māori

Finally, we ask Council to tidy the references in the Draft Statement on achieving best health outcomes for Māori. For example, in reference 1, World Health Organisation should be spelt with a 'z' ie, World Health Organi**z**ation. In reference 13, U.Nations presumably refers to the United Nations and should be spelt out in full.

We hope our feedback is helpful and look forward to seeing the finalised statements.

Yours sincerely

Dr Kate Baddock
NZMA Chair