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Royal Australasian College of Physicians' submission to the Medical Council of New Zealand

Statements on Cultural competence and the provision of culturally-safe care and Achieving the best health outcomes for Māori

July 2019

Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback on the Medical Council of New Zealand's (Council) updated statements on *Cultural competence and the provision of culturally-safe care* and *Achieving the best health outcomes for Māori*.

The RACP works across more than 40 medical specialties to educate, innovate and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our members, to develop policies that promote a healthier society. By working together, our members advance the interest of our profession, our patients and the broader community.

The RACP welcomes Council's leadership in cultural competence, cultural safety and promotion of health equity for Māori as tāngata whenua of Aotearoa New Zealand.

We recognise that the persistent disparities and inequities in health and social outcomes for Māori stem from the impacts and intergenerational trauma of colonisation, and health systems which through their design, structures and implicit value systems are discriminatory and disempowering.

At this point in time, the health and disability system in Aotearoa New Zealand is poised to either capitalise on the findings of major system level reviews, inaugurating significant change and reorienting a system, or to maintain a variant of the status quo. There is increasing demand from society, from patients and whānau, and from health practitioners for the system to acknowledge it is not designed to support everyone's right to health. Statements such as those considered by this consultation can contribute to shifting the balance to equity of outcomes for Māori.

In particular, we acknowledge the recent release of the Waitangi Tribunal's report on the first stage of WAI 2575, Hauora: Report on Stage One of the Inquiry into Health Services and Outcomes for Māori, and the recommendations contained within to contribute to system-level discussions on the reshaping and orientation of the health and disability system in Aotearoa New Zealand[1].

Key points

- The RACP is in general agreement with the statements proposed, with some adjustments recommended to make the intention explicit
- We are encouraged by the language used within this document including reference to "critical consciousness"
- Reference to te Tiriti, mātauranga Māori and tikanga could augment the statement *Achieving the best health outcomes for Māori.*

RACP Indigenous Strategic Framework

The College's Indigenous Strategic Framework 2018-2028 (ISF) sets out our priorities to improve cultural competence, safety and reduce inequities experienced by the Indigenous peoples of Australia

[1] Waitangi Tribunal. Hauora: Report on stage one of the health services and outcomes kaupapa inquiry. Wellington: Waitangi Tribunal; 2019. Available from https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/. Accessed 4 July 2019.

and Aotearoa[2]. We have identified the following key strategies to work towards health equity for Aboriginal and Torres Strait Islanders and Māori:

1. Contribute to addressing Indigenous health equity differences
2. Grow and support the Indigenous physician workforce
3. Equip and educate the broader physician workforce to improve Indigenous health
4. Foster a culturally safe and competent College
5. Meet the new regulatory standards and requirements of the Australian Medical Council and the Medical Council of New Zealand

The ISF centres Te Tiriti o Waitangi and the Uluru Statement from the Heart as key documents supporting the sovereignty of Indigenous peoples in Aotearoa New Zealand and Australia. The RACP supports the moral and ethical responsibilities enshrined in Te Tiriti and is committed to its incorporation into all College activities.

RACP responses to consultation questions

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

1. Do you agree with the proposed definition of cultural competence (in paragraph 14 of the draft revised statement)? Do you have any suggestions on how the draft definition could be improved?

The RACP agrees in general with the proposed definition but would like to make the following comments.

We note that paragraph 13 provides a brief contextual statement on the evolution of cultural competence as a concept, and the "increasing recognition of cultural safety". The RACP finds that while there are many similarities and points of alignment between cultural competence and cultural safety, the two concepts describe different things and should not be conflated together.

- Cultural competence describes the skills, attitudes and knowledge of a practitioner to engage with a patient and the patients' whānau – the practice.

- Cultural safety describes the experience of the patient and their whānau in their interactions with health practitioners and health organisations.

Although influenced by cultural competence, cultural safety is an independent requirement which is not bound to expectations for clinicians to be culturally competent – because it is determined by the patient. While both terms can be utilised within the definition, we recommend Council considers how it deploys each concept, and the context each is used in. One way this could be achieved is by describing a temporal process, stepping through from the overarching mindset of critical consciousness to Council's requirement for doctors to influence healthcare to reduce bias and promote equity.

An edited definition could read as follows, with additions in italics:

[2] The Royal Australasian College of Physicians. Indigenous Strategic Framework 2018-2028. Sydney: The Royal Australasian College of Physicians; 2018. Available from https://www.racp.edu.au/about/board-and-governance/governance-documents/indigenous-strategic-framework-2018-2028. Accessed 2 July 2019.

Council defines cultural competence as

The awareness that cultural competence encompasses a 'critical consciousness' – the concept of doctors engaging in ongoing self-reflection and self-awareness and holding themselves accountable for providing culturally-safe care, as informed by the patient, *their whānau* and their communities.

The commitment by individual doctors to acknowledge and address those biases, attitudes, assumptions, stereotypes and prejudices that may be contributing to a lower quality of healthcare for some patients.

The requirement for doctors to examine the potential impact of their and their patients' *cultures*[3] on clinical interactions and healthcare service delivery.

Council requires *all* doctors, to influence healthcare *at all levels* to *eliminate* bias and promote equity.

There is little reference in Council's draft to the overarching health care systems and structures which determine the organisation and delivery of health services. Doctors work at many levels within the health system, and as individual practice (cultural competence) develops, equally systemic change must be enabled to eliminate bias, promote equity, and ensure culturally safe health organisations and environments.

2. Paragraph 15 of the statement specifically outlines the cultural competence standards Council expects of doctors. Do you agree with the proposed standards? What changes (if any) do you suggest could improve these draft standards?

Paragraph 15 goes into greater detail, unpicking the facets of attitudes, skills, awareness and knowledge to clearly outline the standard expected of doctors by Council. The RACP is generally in support of the standards as proposed; however, we recommend Council make the following changes:

a. Attitudes

Council has used the term "awareness" frequently throughout this document. The RACP finds that "awareness" is a passive word for what should be an active, inquisitive and iterative process to develop insight and knowledge about themselves. An alternative to use in this instance could be "understanding", which implies a greater level of engagement.

In Standard a (ii), it is unclear whose "cultural awareness and practices" the standard is concerned with – is it the doctor having a commitment to developing their own cultural awareness and practices (i.e. of their own culture) **or** is it the doctor having a commitment to developing their own cultural awareness and practices about the culture of another person (who could be a patient, whānau member, colleague or staff member)? The RACP recommends it be clearly identified as both.

Further, there is risk in encouraging people to continue to learn about other cultures by making the culture an object of study. This methodology perpetuates the distancing, difference and objectification of culture as an article of curiosity – "this culture is *other* to me". It is critical for doctors and all health practitioners to understand how systems and structures that were designed

[3] Culture written in the singular form implies there is one "culture" and reduces the diversity, intersectionality and plurality of cultures.

to endorse and maintain the value systems of powerful people simultaneously disempower and marginalise groups within our society.

In standard a (iv), this should read as "A responsibility to challenge the cultural bias of individual colleagues *and/or* systemic bias within health care services, where this will have a negative impact on patients, *whānau or colleagues*".

Although many clinical encounters will take place between a doctor and a patient, there are other actors, such as whānau, colleagues and other staff who may experience racism due to the biases of an individual colleague or experience institutional racism and systemic bias due to culturally unsafe environments. As clinical leaders, doctors have a responsibility to patients, whānau and colleagues, and this includes culturally safe environments.

b. Awareness and knowledge

Similarly to section a (Attitudes) above, the RACP finds the use of 'awareness' in this section and in its heading undermines its intention.

There is little reference in this section to systems, structures, and determinants (such as the historical trauma of colonisation) that impact on health and the need for doctors to understand these associations.

Standard b (iii), which states "An awareness that cultural factors influence health and illness, including disease prevalence and response to treatment", oversimplifies the association, because it omits the influence of the Social and Environmental Determinants of Health. Disease prevalence and response to treatment in many instances is driven by poverty and systemic inequity.

> "The health status of every population is patterned by a great many influences in complex and layered ways that must be understood in order that health interventions be successful. Māori health status in the current context is more likely to be complex because of the overlay of indigeneity. Commentators who propose simplistic descriptions of our health, or those based on shallow analyses, seek to deny us the right to this complexity and the right to fully resourced and informed solutions."[4]

The RACP recommends this standard is augmented to refer to the social and environmental determinants of health, the structure of our health systems, the legacy of colonisation and its impact on intergenerational trauma as factors which determine disease prevalence. The draft standard suggests that culture is independently in and of itself a factor in determining disease prevalence and response to treatment. We find that culture is inextricably located with the other factors outlined above, and a more nuanced statement is required to appropriately describe factors influencing disease prevalence.

Further, a health equity lens calls for equity of outcomes in health care: rather than the reference in Standard b (iii) "response to treatment", which suggests that culture may be a positive or negative mediating factor in responding to treatment, the RACP recommends Council remove this phrase, as it is more appropriately covered in Standard b (v).

In Standard b (vi), the RACP recommends Council amend the draft wording to read as follows (additions are in italics):

> An understanding that the concept of culture extends beyond ethnicity, and that patients *and their whānau* may identify with several cultural groupings.

[4] Reid P, Robson B. Understanding health inequities. In Robson B, Harris R. (Eds). Hauora: Māori Standards of Health IV. A study of the years 2000-2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago; 2007.

c. Skills

In Standard c (iv) Doctors are required to "use cultural information and cultural differences when developing a diagnosis …" This statement establishes a subject/object dichotomy where relational understanding is founded on a basis of othering. The RACP recommends this Standard foreground the patient's cultural preferences first, which implies the doctor has a conversation with the patient rather than making generalisations or assumptions:

Respond to the patient's cultural preferences when developing a diagnosis and formulating a treatment plan that meets these needs as well as being the best clinical pathway.

3. Please provide any feedback about the draft Statement on cultural competence and the provision of culturally-safe care that you think Council should consider.

Where Council refers to "family and whānau", the RACP recommends this is amended to read "whānau". Whānau is commonly used by people of many ethnicities and cultures to describe family, extended family and friend relationships and networks in Aotearoa New Zealand. References to whānau should be integrated throughout the statement, for example references to patients should be expanded to "patients and their whānau". More generally, the RACP urges Council to normalise Te Taha Whānau as a key expression of health care in Aotearoa New Zealand.

Achieving the best health outcomes for Māori: a resource

4. Paragraph 24 outlines how doctors and healthcare organisations can support the achievement of best health outcomes for Māori. Do you think this adequately captures the key points that should be included? What changes (if any) do you suggest could improve this guidance?

The RACP welcomes the updates to Council's statement, previously titled "Statement on best practices when providing care to Māori patients and their whānau". The RACP supports the changes to the Statement's title, which centralises the right to the highest possible standard of health and health outcomes for Māori.

The RACP supports the explicit inclusion of health care organisations in this section of the document. All health care organisations have a responsibility and obligation to the principles enshrined in Te Tiriti o Waitangi.

The five statements providing guidance to doctors could be enhanced by explicit reference to the principles of Te Tiriti as utilised by the Ministry of Health: partnership, participation and protection. For example, statement (e) which highlights the need to "proactively develop policies to improve Māori participation and success at all levels" should contain guidance to proactively partner with Māori to develop meaningful and inclusive opportunities for participation which ensure their success.

Statement (a) should read as:

> "Demonstrating an understanding of Māori indigenous rights as tāngata whenua of Aotearoa New Zealand, and current issues in relation to health and health equity.

The statement contains no explicit call to understand or incorporate Māori models of health, patient and whānau-centred models of care, or mātauranga Māori (Māori knowledge) as part of transformational change for individual doctors or organisation-level systems. Although Council should

not seek to be prescriptive, culturally safe and inclusive models such as Whānau Ora could offer ways for practitioners and organisations to more actively partner to address inequity.

Statement (e) calls for doctors and health organisations to engage in, and show evidence of, transformation with respect to culturally-safe practice. The RACP strongly supports all doctors and health care organisations to engage in conversations and transformational change with health equity and cultural safety at the core. We acknowledge that goals such as eliminating health inequities will take significant time and resources, and it is critical to have milestones to show measurable progress.

5. **Please provide any other feedback about the draft Achieving best health outcomes for Māori: a resource that you think Council should consider.**

The RACP would like to provide Council with the feedback below:

In paragraph 14, statistics are listed describing the impact of social determinants on whānau – for example, unemployment, receipt of benefit and household crowding. While many of the statistics quoted are relevant in 2019, "living in a household without a telephone" – meaning a fixed-line telephone – may be less of an issue as more households are no longer paying for fixed lines – the Commerce Commission has reported fixed-line call minutes were down from 12 billion call minutes per year in 2007/08 to around 5 billion in 2016/17[5].

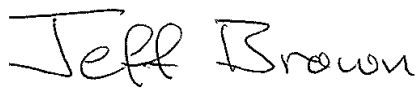
Paragraph 15 lists areas of inequity for physical health conditions experienced by Māori, including cardiovascular disease, stroke, rheumatic fever and lung cancer. In recognising the critical importance of frameworks and models of Māori health, such as Te Whare Tapa Whā, the RACP would amend this paragraph to state health inequities experienced by Māori in other domains of health and wellbeing – particularly mental health, addiction and suicide; as well as access to primary health care.

We recommend Council exhibit bicultural partnership in the production of this document by additions including (1) parallel translation into Te Reo Māori, and (2) incorporation of characteristic Māori literary devices such as whakataukī. We recommend Council consult with its Māori cultural advisors as to how these things can be achieved.

Conclusion

The RACP thanks Council for the opportunity to provide feedback on this consultation acknowledges Council's leadership in cultural competence, cultural safety, partnership and health equity for Māori. To discuss this submission further, please contact the NZ Policy and Advocacy Unit at policy@racp.org.nz.

Nāku noa, nā



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[5] Commerce Commission. Annual telecommunications monitoring report: 2017 key facts. Wellington: Commerce Commission; 2017. Available from https://comcom.govt.nz/regulated-industries/telecommunications/monitoring-the-telecommunications-market/annual-telecommunications-market-monitoring-report. Accessed 3 July 2019.