Cultural Competence: A discussion paper by the Māori Health Committee

The rationale for this document is that physicians and paediatricians want to ensure best health outcomes for their patients. Best health outcomes also result in greater job satisfaction for practitioners. Cultural competence will contribute to best health outcomes for Māori and all patients. Cultural competence cannot be separated from clinical competence.

Introduction

The Royal Australasian College of Physicians (the College) has the responsibility to ensure that cultural competence underpins its role in the training and professional development of its trainees and Fellows. Cultural competence needs to inform the content and delivery of education and training programmes for both physicians and paediatricians. One of the key roles of the Māori Health Committee is to advise on how to bring about change within the health sector, namely to seek to reduce the health inequalities that currently exist between Māori and non-Māori.¹ In both New Zealand and Australia there is a clear disparity between indigenous peoples (Aboriginal & Torres Strait Islanders (ATSI) and Māori) when compared to non-indigenous peoples, and some of this gap is attributable to practice; therefore, through promoting cultural and clinical competence the College should be able to address reversible gaps through improved service delivery.

Under the College’s Professional Qualities Curriculum, physicians and paediatricians have a responsibility to manage and develop their own cultural competence and to familiarise themselves with the differing cultures within their communities.² In order to achieve this aim, Fellows must have access to relevant resources; they need to be provided with guidance on how they may be culturally competent and additionally they must be provided with some objective way to measure their cultural competence.

Section 118(i) of the Health Practitioners Competence Assurance Act 2003 (the Act) states that regulatory authorities (the Medical Council of New Zealand) need “to set standards of clinical competence, cultural competence and ethical conduct to be observed by health practitioners of the profession.”³ Due to our relationship with the Medical Council of New Zealand as a Branch Advisory Body (BAB), the College is encouraged to develop standards of practice relating to cultural competency. Cultural competency is central to the College’s accreditation process with the Medical Council of New Zealand; therefore, developing a robust cultural competency programme is essential for the College.

The Māori Health Committee (the Committee) recognises that cultural competence must be a core competency for physicians and paediatricians and that clinical competence requires cultural competence. The Committee’s role is to provide advice and leadership on matters relating to Māori cultural competence.⁴

¹ Māori Health Committee By-Laws
³ Health Practitioners Competence Assurance Act 2003 s118(i)
⁴ Māori Health Committee by-laws
What is cultural competence?

The Medical Council of New Zealand has defined cultural competence in the following terms:  

“Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge:

- That New Zealand has a culturally diverse population.
- That a doctor’s culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor-patient relationship.
- That a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding.”

The Medical Council of New Zealand extends the notion of cultural competence to include not only ethnicity but “…those related to gender, spiritual beliefs, sexual orientation, lifestyle, beliefs, age, social status or perceived economic worth.” The Committee at this stage wishes to focus on developing a culturally competent physician workforce in order to improve the health outcomes of Māori. The Committee recognises that there are many cultures in New Zealand/Aotearoa; however it is their mission to work for better outcomes for tangata whenua (indigenous people of the land) consistent with the Treaty of Waitangi and New Zealand’s health goals.

To be culturally competent, the Medical Council of New Zealand requires that a medical practitioner demonstrates the appropriate attitudes, awareness, knowledge and skills towards his/her patients irrespective of the patient’s cultural background. The Committee’s discussions are consistent with these principles. The objective of the Committee is to encourage all physicians and paediatricians to have enhanced inter-cultural competence.

The Committee believes that becoming culturally competent has three phases:

- first, understanding that practitioners themselves are culturally located and communicate their culture within clinical encounters;
- second, understanding the diversity of cultures of their patients and the impact of culture on patients’ behaviours (especially appreciating stereotypes can be misleading);
- and third, learning the tools to assist a practitioner’s engagement with patients’ cultures.

The Committee is advocating open inter-cultural dialogue between the practitioner and patient as a means of enhancing cultural competence. This will improve patient outcomes by practitioners being culturally responsive to all patients. This can lead to enhanced job satisfaction for practitioners by providing better patient outcomes to Māori patients.

The New Zealand Adult Medicine Division Committee has concluded, through discussion that cultural competence hinges on:

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7 NZ Adult Medicine Division Council meeting minutes 5 March 2010
• Having open communication, including good listening skills.
• Respecting the patient’s culture. Are there particular things I need to know so we may work together to ensure a good outcome?
• Having the time to engage with the patient and understanding their perspective.
• Demonstrating to the patient that as a health professional you care for them.

Cultural competence is not just related to Māori culture but relates to all cultures; however, it is within the Māori context where the Committee may assist the College in developing relevant Māori cultural competence programmes that will often include the family/whanau participation.

The Committee sees its role as providing advice and assistance to the College committees by working collaboratively with those committees in order to enhance the cultural competence of Fellows and trainees. In New Zealand, the Committee wishes to ensure that there are adequate resources to assist with Māori cultural competence. It should be noted that there is a culture of medical practice, a culture of the hospital and that all patients have their own cultural perspective.

Programme Implementation

It was agreed that the Committee needs to work within existing College structures to promote cultural competence. The College’s professional development programme, MyCPD, would be the most accessible method to foster cultural competence to the Fellows.

The Committee members favour a voluntary approach in the first instance, although the members are conscious of the Medical Council’s requirements and those principles articulated in the Health Practitioners Competence Assurance Act 2003.

The Committee’s view is that cultural competence initiatives needed to be implemented as soon as practicable across all levels of the College’s activities and include trainees, Overseas Trained Physicians (OTPs), Fellows and College officers. In this context it would seem that commitment is needed from the entire College, although there are differences culturally between New Zealand and Australia. However, it is unlikely that all individuals or groups within the College have the same level of understanding or knowledge with regards to cultural competence. It is only when an individual reflects on their own understanding of cultural competence or when they engage in a cultural competence programme that they became aware of their own level of competence.

The Committee recognises that there are three main groups within the College that tailored cultural competency programmes need to be developed for:

1. Fellows: MyCPD can be used to engage Fellows in cultural competence. Fellows are able to assign CPD hours to cultural competence and/or Māori health. The Māori Health Committee is working with the NZ CPD Committee to develop resources to assist Fellows in this area. Educational supervisors may also be approached to ensure cultural competence is embedded in their activities.

2. Trainees: It is acknowledged that trainees may have a greater understanding of the principles of cultural competence given the recent programmes developed by the medical schools. However the College needs to cognisant that the PREP programme and other initiatives being developed by the College address cultural competence in a meaningful way by providing trainees with the tools to apply cultural competence principles in their daily practice.
3. OTPs: A key group as many are working in provincial hospitals where there may be higher proportions of Māori patients. Once vocationally registered as a physician, these individuals must participate in the College’s CPD programme. For some OTPs additional guidance will be needed on the most effective ways to work with indigenous populations.

Assessment

It is perhaps easy to identify when a practitioner is not being culturally competent. However it is more difficult to identify and objectively measure when a practitioner is being culturally competent.

In the Committee’s view cultural competence is essentially about attitude.

The Committee considers that there is no easy solution to measuring or assessing cultural competence. The Committee does believe that programme participation is an essential first step in becoming culturally competent. In time, cultural audits could be developed. In developing measures of cultural competency patient focused outcomes need at least equal consideration to physician participation.

Cultural competence assessment could be integrated into already existing assessment methods used by the College. Cultural competence questions could be added to written exams, reflective statements, mini-CEXs, Serious Incident Analysis, multisource feedback. Interactions with Māori families/whānau could be observed as part of the clinical examination process.

If a more formal approach was required to assess the cultural competence of Fellows then the annual CPD audit could be amended to include evidence of a minimum commitment to cultural competence.

The Committee remains interested in the new assessment tools that are emerging in the broader NZ health system and will continue to examine these tools and their applicability to the RACP.

Conclusion

- The Committee recognises that cultural competence must now be accepted as a core competency for physicians and paediatricians. Improved competency will lead to best patient outcomes and enhanced job satisfaction, as well as compliance with the Act. It is important that practitioners understand the importance of culture and learn the tools to engage with the cultures of their patients.
- The Committee has adopted the Medical Council of New Zealand’s definition of cultural competence due to our relationship with them as a Branch Advisory Body.
- The Committee sees its role within the College as providing advice and assistance with respect to Māori patients and their culture. While the Committee is not charged with producing all documents relating to other cultures there are clear synergies and similarities in the acquisition of cultural competence with respect to other ethnicities.
- The Committee’s view is that cultural competence initiatives need to be implemented as soon as practical across all levels of the College’s activities. However there needs to be further work in developing these tools and activities.
• Any programme on cultural competency should be aware of existing cultural strategies and utilise current College structures. The Committee’s current focus is on assisting the delivery of a cultural competence programme to Fellows through MyCPD.
• The Committee recognises that there are a range of cultural competency developments within the broader health system, and that RACP should be aware of other relevant approaches;
• The Committee recognises that it will be necessary to measure or assess cultural competence. Programme participation is the first step in measuring cultural competency at this time.

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