

AUSTRALIAN AND NEW ZEALAND BOARDS AND COUNCIL CONFERENCE

**CULTURAL COMPETENCE
AND
MEDICAL PRACTICE
IN NEW ZEALAND**

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Cultural Safety and Cultural Competence

Although the differences between cultural competence and cultural safety are probably outweighed by their similarities, they have quite distinct starting points and in the New Zealand health context, somewhat different histories. Both are about the relationship between the helper and the person being helped, but cultural safety centres on the experiences of the patient, or client, while cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context. This last point is important. Recognition of culture is not by itself sufficient rationale for requiring cultural competence; instead the point of the exercise is to maximise gains from a health intervention where the parties are from different cultures.

Political correctness is often seen as the driving force for cultural recognition, and the battle for cultural safety, fought largely by colleagues in the nursing profession and the Nursing Council, was widely regarded as an over-enthusiastic response to PC. There was indeed a political element to the debate – in so far as the Treaty of Waitangi has a political dimension, and advocacy for political safety was linked to the Treaty – political connotations were inevitable. But during the ensuing controversy, conducted not only in the media but also in the Courts and the Council room, the relationship between cultural safety and health was often overlooked in favour of the more sensational relationship between cultural oppression and Māori rights. The issue, primarily about health, had become transformed into an issue of indigenous rights. There is of course an important link between indigenous rights and health gains but the debate, as reported, seldom explored the link. Yet despite the media bias, and to its great credit, the Nursing Council refused to back away from the substantial evidence that culture and health gains were associated, and cultural safety was reaffirmed as an integral part of nursing education and professional registration.

Meanwhile, and thus far in a much less public way, the Medical Council is considering the issue and has opted to emphasise cultural competence rather than cultural safety. The shift in emphasis from safety to competence may not reflect any fundamental difference between medicine and nursing but suggests a desire to move the debate onwards, away from its political associations and towards a health-oriented justification. But quite apart from cultural safety, there are other reasons as well, more pragmatic perhaps, that justify the medical profession's interest in the subject.

A Changing Demography

First New Zealand's demographic profile is changing as the growth in the Māori population continues. Although accounting for some 15 percent in 1996, by 2051 the Māori ethnic population will almost double in size to close to a million, or 22 percent of the total New Zealand population. By 2006 Māori will make up a quarter of the total New Zealand school age population. Even more dramatic, by 2051, 33 percent of all children in the country will be Māori, and Māori in the working age group, fifteen to sixty-four years, will increase by 85 percent.

Second, the overall ethnic diversity within New Zealand is undergoing similar change. High fertility rates, quite apart from further immigration, will lead to significant increases in Pacific Peoples. Migrants from India, China and the Asian Pacific rim will add to the cultural diversity so that by 2050 around half of New Zealand's population will be non-European. The composition of the medical profession will, in time, come to match the community profile, but for now the immediate implication is that doctors will increasingly be called upon to treat patients from different cultural backgrounds. English, while still likely to be the common language may not be the preferred language and health providers will be sorely tested to respond positively to consumers whose cultural and ethnic roots lie outside their own experiences. More to the point, unless interaction with patients recognises and builds on cultural realities, opportunities for gains in health may be lost.

Third, the shrinking globe, made smaller by www.com and an array of electronic networks, as well as greater opportunities for travel to and from New Zealand, will bring a previously insular nation into a wider cultural arena. Whether practicing in New Zealand or abroad doctors will not be immune from the globalising influence; cross-cultural interfaces will become the norm; medical effectiveness will be increasingly challenged by cultural diversity; and the capacity to embrace other cultures in a confident manner could make the difference between good outcomes and treatment failures.

Cultural Competence - Domains and Application

Culture is essentially a convenient way of describing the ways members of a group understand each other and communicate that understanding. More often than not the nuances of meaning are generated by behaviour rather than words, and much of the interaction between members is determined by shared values operating at an unconscious or 'taken for granted' level. Many groups have their own distinctive culture – the elderly, the poor, professional groups, gangs, the army. Although in this paper the focus is on culture associated with particular ethnic groups, it should not be forgotten that in the consulting room or the hospital ward, ethnic culture is one cultural affiliation alongside others. The fact that an fourteen year old boy is a Māori for example, may be less relevant in health terms than the fact that he is fourteen. Youth, and its distinctive cultural characteristics might be the more significant reality. At the same time a fourteen year old boy who is Māori is likely to have perspectives that are not completely shared by youth from other cultural backgrounds. The skill lies in being able to determine the culture that is likely to have the greatest significance in a specific context.

Cultural competence is about the acquisition of skills to achieve a better understanding of members of other cultures. Consistent with the view that it is less about behaving correctly and more about practising sound medicine, cultural competence is essentially another dimension to the doctor patient relationship that can provide doctors with additional information necessary for better clinical results. A doctor who is culturally competent can use cultural impacts to improve performance in at least four areas:

<i>Domains of Cultural Impacts</i>	<i>Professional Gains</i>
<ul style="list-style-type: none"> • health perspectives • values • symptom hierarchies • community capacity 	<ul style="list-style-type: none"> • conceptual understanding • professional practice • diagnosis • treatment and care

Culture and Paradigms of Health - Conceptual Understanding

Medical practitioners have understandings of health that are based on scientific method. Cause and effect are linked by evidence and evidence is based on substantiation that satisfies the criteria of scientific proof. Doctors bring the scientific model to the consulting room and more or less expect that their patients will subscribe to similar beliefs. For the most part New Zealanders, including Māori and Pacific Peoples accept the scientific ethos. But they may also hold views that are at odds with science.

One example of a non-scientific belief system is found in the concept of synchronicity. Carl Jung used the term synchronicity to describe the significance given to the simultaneous occurrence of events not obviously related in a scientific cause and effect manner. He believed that patterns of meaning were connected to time and that events that occurred at similar times were therefore related.

For many Māori people synchronicity is a valued experience. Two events seemingly unrelated take on a new meaning when they are linked together by time. The death of two people on the same day or during the same week for example, creates a bond between the families not for any reason other than sharing a similar moment in time. In an attempt to explain the relationship rumours may circulate attributing the causes of death to the same illness or exposure to a common agent; perhaps the same doctor treated them. But it is time that binds the events, not causality.

Confusion comes when the relationship between the two events is reconfigured in cause and effect terms and is either supported through quasi scientific rationale or refuted because it does not meet scientific criteria. Those who experience the force of

synchronicity do not necessarily reject science. But there is a reluctance to be bounded by science; other knowledge systems are also respected. This is not new to the many doctors who also believe in more than one system of knowledge. The doctrine of the Holy Trinity and the Resurrection, for example, cannot be explained except as articles of faith. Yet many professionals who at the same time have absolute confidence in scientific rationality hold them dear.

Cultural competence is about recognising other belief systems without needing to defend science as the only legitimate way of looking at the world. What is important is to know that the patient may only partially accept the medical explanation, and will therefore not share the same enthusiasm for scientifically based treatment. The consequence is that in addition to the medical approach, the patient may seek the opinion of a traditional healer or cultural advisor. One approach does not negate the other. As New Zealand becomes increasingly culturally diverse, doctors will need to share the healing platform with others who do not base their interventions on scientific evidence. Rather than regarding the other healers as threats or interlopers, a culturally competent doctor will see opportunities for collaboration.

Culture as a Source of Values - Professional Practice

The single most reliable pathway to culture is language. The language spoken by a group contains subtleties of meaning and an idiom that is not accessible in formal speech or through the written word. In a nation of many cultures and languages, however, it is unlikely that doctors will be conversant in them all, or even in two. The challenge therefore is to understand culture, if not through language then by appreciating the values upon which cultural integrity is based.

Underlying most cultures is a set of values that may well be taken-for-granted by members of the group and in that sense are not openly discussed nor widely publicised outside the group. New Zealand men for example, often minimise a health problem, setting great store by the value of understatement. Doctors who intuitively understand that value will tend to be alert to the quiet complainant knowing that the low key style

could well mask a serious condition. However, without any prior knowledge of the Kiwi value system, an unwary doctor who took the tendency towards understatement as an accurate description of an actual situation, could well err on the side of inadequately investigating a complaint. Values are not always overtly acknowledged even though they are intuitively recognised and understood by members of the same cultural group. They are applied as a matter of course. Difficulties arise when the doctor with a different value system is not able to interact at the intuitive level so that the nuances of interaction are missed or even unintentionally dismissed.

To illustrate the point, Māori patients often hold values related to the utilisation of space and time. The values are more obvious on a marae where, for example, physical distance is maintained between visitors and hosts until certain rituals have been completed paving the way for a closer relationship. Traversing the space prematurely can cause offence and create unease. Space allows any risk from an encounter to be assessed before a commitment is made. Similarly on a marae the value of time takes on a different meaning. Being 'on time' gives way to allowing sufficient time, even if it goes against the logic of the clock. Priority is given to enabling the completion of essential tasks in an orderly manner; the time taken for completion is a relatively minor consideration.

Less widely recognised is how the same values surrounding space and time continue to be applied beyond the marae, probably intuitively rather than deliberately. In the surgery or clinic, patients may be uncomfortable where there is a lack of physical space, at least until the terms of the encounter have been defined. When the physical distance between patient and doctor is restricted the opportunity for the patient to assess any risk in the encounter is diminished. Sometimes where space is unduly constrained the architecture can be blamed; but equally professional good intention may be at fault; a well meaning attempt to immediately bridge distance can be interpreted as a threat or intrusion.

Values surrounding time can be similarly misconstrued in the clinical setting. Concern about the full waiting room and the limited time available to do each patient justice can lead to the construction of an agenda based on the clock rather than personal priorities.

Indeed most medical schedules are time-based rather than problem-based. If it is obvious that time is severely rationed, many Māori patients, and others, will be reluctant to embark on a narrative if it seems they will be unable to complete the story, and may simply opt for a face-saving superficial encounter that bypasses the substantial matter.

Where professional practice does not allow for time and space to be valued, it will be an uphill battle to establish a working relationship between doctor and patient. An approach that is professional according to one set of values, may be seen as a disregard for other value systems, and will inevitably reduce the effectiveness of the consultation.

Of course not all Māori patients subscribe to these values to the same extent or even to any extent. But a competent doctor will be aware of the possibility and will be careful not to impose a value laden professional manner on a patient whose expectations may be derived from other notions of professionalism.

Culture and Symptom Hierarchies – Clinical Acumen

The classification of disorders, and diagnostic criteria, has a universal dimension that encourages doctors in Moscow to use similar standards to doctors in Wellington when assessing a patient. The signs and symptoms of an appendicitis, or otitis media transcend cultural and ethnic boundaries. However, the relative weighting attached to symptoms is less constant. Between cultures there are different symptom hierarchies and different interpretations of both severity and importance. A case in point is depression, thought to be a widespread disorder in New Zealand, with a life time prevalence in the range of ten to twenty percent.

Although regarded as a mental disorder, the symptoms of depression are as much physical as mental and for many patients it is the physical distress that causes the greater suffering. Moreover there is considerable evidence that depression manifests itself differently in different cultures. Patients in Western eurocentric cultures are more likely to complain about the emotional and psychological aspects of the illness while many non-

Westerners are much more worried about the physical aspects: loss of energy, debilitation, weight loss, abdominal pains, poor appetite, sensitivity to cold.

In non-western cultures depression will not necessarily be regarded as a mental disorder but as a disorder of energy, or gastro-intestinal malfunction, or sleep disturbance. While definitive studies have yet to be undertaken, clinical experience suggests that Māori patients who have a depressive disorder are not necessarily overwhelmed by symptoms of sadness, or hopelessness, or unhappiness. Nor does guilt or self accusation dominate the picture. What becomes troublesome, however, is the presence of physical symptoms - diminished appetite, inability to sleep, loss of weight, musculo-skeletal pains, reduced libido, and a feeling of coldness. Attempts to dismiss the physical symptoms as 'only depression' may lead to a loss of confidence in the doctor. Māori have always struggled to accept the division of illness into physical and mental disorders. The demarcation is never that clear. Pukuriri, the word for fury or hostility, locates feelings of anger in the stomach (puku) rather than in the head. Manawa-pa (apprehension) and manawa-pouri, a term for sadness, link anxiety and depression not with the mind, or with free floating emotions but with the heart - manawa. In any event, while depression may be a universal ailment, its presentation is largely coloured by cultural variations in the way symptoms are ranked.

A number of implications stem from the non-universality of clinical presentations. First, standard textbook descriptions cannot be regarded as equally applicable to all cultural groups. Second when dealing with a mixed patient population, doctors should be mindful of the varying emphases that will be placed on physical, emotional, and mental symptoms. The western tendency to distinguish physical and mental disorders may alienate patients who do not subscribe to a sharp division between mind and body. Third, understanding cultural perspectives, especially as they impact on health, will aid the diagnostic process.

Culture and Community Capacity – Treatment and Care

A fourth area where cultural competence can contribute to greater medical efficacy lies in the social norms and organisation within different communities. While an individual patient may be the focus of attention, more often than not successful treatment and care will depend on a wider circle of friends and family. In turn that will require the doctor to have some familiarity with the patient's community at least to the extent that a judgement can be made about the most useful therapeutic arrangements that might assist with care and management. A decision to discharge from hospital for example could be viewed differently in light of first hand knowledge of circumstances beyond the ward.

The measurement of patient satisfaction and patient outcomes is also a matter where cultural views are important. A mental health outcome measurement tool for Māori, *He Hua Oranga*, draws heavily on Māori perspectives of health and records the impact of treatment on spiritual health as well as mental health. In addition it allows for community input into the process by way of the whānau, the doctor's assessment of treatment being only one input into a three-way process that involves consumer, whānau, and doctor.

Within Māori communities there are a wide range of facilities, whānau support mechanisms, committees and health services. However, they are not identical and an effort should be made to match patient need with community capacity rather than assuming that they are all equally applicable. Simply leaving care or follow-up treatment to the whānau to 'sort out' is not an acceptable discharge of responsibility. Sometimes the doctor uses the excuse of lacking the necessary cultural skills to off-load a patient. By the same token ignoring the cultural reality as is it were of little consequence may lead to missed opportunities for positive interventions. Treatment plans that are developed without regard for whānau and community cultures, run the risk of failing, not because they are professionally and technically inappropriate but because the community's cultural ethos is aligned to other priorities and other methodologies.

A culturally competent doctor must therefore have both knowledge and information about the cultural communities serviced by the practice or clinic. It enables a more accurate picture to be drawn about the environmental opportunities for health, as well as the health risks, and it allows for innovative ways of delivering health services. The evolution of a large number of community based Māori health services for example provides an opportunity for doctors to work in association with Māori providers. Managing that relationship will demand additional skills and may result in the doctor playing more of an advisory and facilitatory role, somewhat removed from the immediate clinical interface. Otherwise a system of competing and duplicated services could evolve

Implications of Cultural Competence for the Medical Profession

The Role of the Doctor

In order to avoid fragmentation and to make better use of the health dollar, an important aspect of current health service delivery is therefore collaboration between providers. As the interdisciplinary boundaries are redrawn questions about role inevitably surface. Where can doctors make the most difference and when should they stand aside for others? There are many parameters to that debate and it has already been rehearsed in relationship to maternity services, well-child care, mental health care and rural health services, though without absolute resolution. Role is also part of the debate surrounding cultural competence. What health services are best performed by cultural groups themselves, on the grounds that they will be better placed to deliver a more effective service, and in that event is there a continuing role for doctors? Rapid and ongoing changes in the New Zealand health sector over the past decade have highlighted the issue and beg the question whether cultural competence means adding cultural skills to an already taxed information base or simply making way for new providers who are already culturally skilled. These are matters that the medical profession, in association with others, has yet to debate, and probably they are beyond the scope of this paper; but they touch on the relevance of cultural competence and the relationship of the medical profession to the wider health sector, if not to New Zealand society itself.

Workforce Composition

It is generally accepted that the professional workforce responsible for education, health, justice, or social services should match the community it serves. Medicine took a lead in that goal by establishing an affirmative action programme at Otago University in 1900 and reserving two positions in the Medical School for Māori students. Tutere Wirepa and Peter Buck (Te Rangi Hiroa) were the first to enter the scheme and the centennial of their graduation will occur in 2004. Since then the scheme has been extended to include Pacific students and at both Auckland and Otago the numbers from each group have increased dramatically. But, given the changing New Zealand demography it will be some time yet before the medical workforce matches community profiles. Meanwhile the Medical Council is developing an ethnic data base that will enable a more accurate assessment of cultural profile of the medical workforce.

Of concern, however, is the reported exit of New Zealand trained graduates and specialists and an increasing reliance on overseas doctors. The trend, if it becomes a pattern, will have significant implications for cultural competence. On the one hand it is likely that overseas doctors will have had greater exposure to multi-cultural societies and may be more accustomed to working across cultures than their New Zealand counterparts. But on the other hand, the peculiarities of New Zealand society, and the emerging patterns of health care delivery, will present them with new challenges. As if understanding New Zealand humour were not challenge enough, there will be expectations that they will be able to apply the Treaty of Waitangi to medical practice, come to grips with the apparent contradictions of social informality yet social reserve, understand the implications of mate Māori, and take into account the male propensity for understatement.

Registration and Ongoing Medical Education

If, as earlier suggested, it is necessary to produce the best possible health outcomes, should cultural competence be assessed both for registration and as part of an ongoing professional education requirement? New Zealand graduates, at least since the 1970s

will have had some exposure to the impacts of culture on health in undergraduate years. But it is unlikely that the introductory lectures and experiences, by themselves, will be sufficient for later years in vocational practice. Some specialist colleges are clear about requirements for cultural competency in post-registration qualifications; others are still considering the issues. In any case cultural competency must be regarded as a necessary skill and should therefore be included in ongoing education and assessment.

Because doctors coming to New Zealand from overseas may not have had formal training in cultural competency, and will not necessarily have any understanding of the New Zealand mix, the question arises as to whether their registration should be dependant on a demonstration of those skills – or at least some familiarity with the broad issues. At the very least it would signal to prospective applicants that cultural issues were regarded as integral to health advancement, and that New Zealand had its own distinctive cultural characteristics. How cultural competency is assessed is another matter though in line with the problem based approach to medical education, a case could be made for it to be closely linked to clinical problem solving, rather than treated as a separate subject that stood outside a medical framework. By emphasising the clinical-cultural link, the rationale for cultural competency is clearly based on health objectives rather than political imperatives. While the two levels of justification may not be absolutely separable, the more cultural competency is perceived as a non-medical issue, the less it is likely to be integrated into practice.

A Cultural Competence Framework

Cultural competence embraces many variables several of which have been discussed in this paper. While inevitably it is an incomplete analysis, there are sufficient pointers to construct a framework within which cultural competence can be considered. The twelve point framework can be configured as a four-part construct made up of:

- an over-arching aim
- four domains of cultural impact
- four applications to medical practice
- three implications for the medical profession

The overarching aim of cultural competence is to maximise health gains from an intervention where the parties are from different cultures. Within this aim, cultural impacts are recognised as important for the achievement of best health outcomes.

The domains of cultural impact have been identified as:

- health perspectives
- values
- symptom hierarchies
- community capacity

Corresponding *applications to medical practice* embrace:

- conceptual understanding
- professional practice
- clinical acumen
- treatment and care

Finally, three *implications for the medical profession* are considered:

- the role of the doctor
- workforce composition
- registration and ongoing medical education

A graphic representation of the framework is shown below for clarification.

Because there is neither a single rationale for cultural competence nor a universally accepted framework for considering its significance to medicine, the 12-point cultural competence framework presented here must be regarded as tentative, incomplete, and insufficiently detailed to be cast as a schedule. However, the objective has been to scope the issues and to present them in a way that might guide further discussion.

Figure 1 *A Cultural Competence Framework*

