

CCPHE Consultation - Organisation Submissions

	Submitter		Organisation
1	Larsen	Bronwyn	Canterbury District Health Board
2	Sharman	Glenys	Chiropractic Board of New Zealand
3	Edmond	Jackie	Family Planning New Zealand
4	Wilson	Janice	HQSC - Health Quality & Safety Commission
5	Pitama	Suzanne	MIHI - Maaori Indigenous Health Institute, University of Otago Christchurch
6	Rumball-Smith	Juliet	Ministry of Health
7	Dumble	Felicity	NZCPHM - New Zealand College of Public Medicine
8	Metcalfe	Adrian	NZCUC - New College of Urgent Care
9	Baddock	Kate	NZMA - New Zealand Medical Association
10	Manson	Leanne	NZNO - New Zealand Nurses Organisation
11	Hagen	Kathryn	NZSA - New Zealand Society of Anaesthetists
12	Hill	Alison	PHARMAC
13	Norman	Lance	ProCare Health Limited
14	Stolarek	Iwona	RACMA - Royal Australasian College of Medical Administrators
15	Hill	Nicola	RACS - Royal Australasian College of Surgeons
16	Devenish	Celia	RANZCOG - Royal Australian and NZ College of Obstetricians and Gynaecologists
17	Hadden	Peter	RANZCO - Royal Australian and NZ College of Ophthalmologists
18	Lawrence	Mark	RANZCP - Royal Australian and NZ College of Psychiatrists
19	Lau	Gabriel	RNZCR - Royal Australian and New Zealand College of Radiologists
20	Tynan	Peter	RNZCGP - Royal New Zealand College of General Practitioners
21	Dougan	Fionnagh	Capital and Coast District Health Board
22	Brown	Jeff	The Royal Australasian College of Physicians
23	Mitchell	Leon	Midwifery Council
24			Anonymous group submission via survey monkey

Canterbury

District Health Board

Te Poari Hauora o Waitaha

Submission on draft Statement on Cultural Competence and the Provision of Culturally-Safe care *and* Draft Achieving best health outcomes for Māori: a resource

To: Medical Council of New Zealand

Submitter: Canterbury District Health Board

Attn: Bronwyn Larsen
Community and Public Health
C/- Canterbury District Health Board
PO Box 1475
Christchurch 8140

Proposal: Medical Council of New Zealand (Council), in partnership with Te Ohu Rata O Aotearoa (Te ORA) is reviewing its existing statements on Cultural Competence and Best practices when providing care to Māori patients and their whānau.

SUBMISSION ON DRAFT STATEMENT ON CULTURAL COMPETENCE AND THE PROVISION OF CULTURALLY-SAFE CARE AND DRAFT ACHIEVING BEST HEALTH OUTCOMES FOR MĀORI: A RESOURCE

Details of submitter

1. Canterbury District Health Board (CDHB).
2. The Ministry of Health requires the submitter to reduce potential health risks by such means as submissions to ensure the public health significance of potential adverse effects are adequately considered during policy development.

Details of submission

3. We welcome the opportunity to comment on the draft Statement on Cultural Competence and the Provision of Culturally-Safe care and Draft Achieving best health outcomes for Māori: a resource.

General Comments

4. The CDHB supports in principle the definitions and standards included within both these documents. However careful consideration is needed as to how such principles and standards will give effect to meaningful changes in practice.
5. Power imbalances which perpetuate inequities within the health system will not be reduced unless doctors, alongside other health professionals, are supported to take action towards developing cultural competence and creating cultural safety.
6. The recognition of fundamental power imbalances between doctor/patient interactions, and a health system by which a western model of medicine remains dominant, needs to be strengthened in these statements. The CDHB recommends that as per the previous version, more emphasis is placed on practicing mutual respect and understanding and acknowledging diversity and difference.
7. There are challenges with presenting cultural competence as a set of standards which can be achieved, instead of an evolving process of developing increasing self-awareness, demonstrating an increasing knowledge base of various cultural norms and practices from experience of working with people of various cultures, and continuously advancing interpersonal skills in order to create culturally safe environments which elicit practitioner/patient/whānau trust and challenge both

personal and systemic drivers of inequality¹. Such a process is not finite and will continue to evolve over a doctor's career.

8. The CDHB recommends that actions are included to provide guidance to doctors as to how they may achieve the standards set out in paragraph 15. An attempt to do so is acknowledged in paragraph 24 of Achieving Best Health Outcomes for Māori: A Resource, however these are still presented as overarching concepts and not practice guidance.

Conclusion

9. Thank you for the opportunity to submit.

Person making the submission



Evon Currie

Date: 5/07/2019

General Manager
Community and Public Health

Contact details

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For and on behalf of
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¹ Testa. D. 2017. *Hospitals, nationality, and culture: Social workers, experiences and reflections*. *Aotearoa New Zealand Social Work* 29(2), 96–107.

20th June 2019

This submission has been prepared on behalf of the New Zealand Chiropractic Board.

Medical Council of New Zealand consultation on its review of the existing statements on *Cultural Competence and Best practices when providing care to Māori patients and their whānau*. - June 2019

Via email: SConsultation@mcnz.org.nz

Thank you for the opportunity to make a submission to the review of your existing statements on *Cultural Competence and Best practices when providing care to Māori patients and their whānau* consultation. The New Zealand Chiropractic Board supports your review.

We offer several comments and suggestions we feel may support clarity of some statements:

Draft 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?

Draft statement:

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

- a) This statement does not specify whose biases, attitudes, assumptions, stereotypes and prejudices need to be acknowledged and addressed. Is it the individual practitioner, their colleagues or patients? If, as inferred by the word 'any', this means all three, this is a significant responsibility and may not be appropriate.

Draft statement:

Council requires doctors to influence healthcare to reduce bias and promote equity

- a) This statement is ambiguous. Are doctors required to influence healthcare across their profession, inter-professional, across the public and at other levels?

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?

Draft statement on Attitudes

- a) Suggest changing the word 'bearer' or suggested improvement: "Being culturally competent requires a consciousness and ownership of your own culture with its intrinsic history and attitudes...."

Draft statement on Skills

- I. *Establish connections with patients from diverse backgrounds.*
 - a) Suggest replacing the word 'connections' with 'rapport'
- II. *Elicit cultural factors important to the patient which might impact on the doctor-patient relationship.*
 - b) Suggest replacing the word 'elicit' with 'identify'
- III. *Recognise when your actions might not be acceptable or might be offensive to patients.*
 - a) How would a practitioner "recognise" their actions might not be acceptable or might be offensive?
 - b) Suggested change: Culturally self-assess and learn to recognize when your actions might not be acceptable or might offensive to patients
- IV. *Use cultural information and cultural differences when developing a diagnosis and formulating a treatment plan that responds to both the cultural preferences of the patient and the best clinical pathway.*
 - a) Suggested change: "Develop diagnoses and formulate treatment plans that fit within the patients' cultural context, but are balanced by the need to follow 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.

Statement 12. Evidence suggests that there are risks associated with focusing on the acquisition of knowledge about 'other cultures' such as inappropriate generalizing and stereotyping.

- a) This statement is ambiguous. As presented, the purpose or intent of this statement here is not as clear in this context as in the subsequent document.
- b) If stating 'evidence', should this be referenced and is the reference contemporary

Draft Achieving best health outcomes for Māori: a resource

4. Paragraph 27 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?

- a) We were not able to locate paragraph 27 and assumed it should be paragraph 24 and we agree with how it is written.

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

- a) We were interested to know if the Medical Council found it difficult finding more recent references. We noted several references were more than 10-years old.

Thank you for the opportunity to comment on the proposal. We are happy to speak to our submission and answer any questions.

Sincerely,

GSSharman

Glenys Sharman

Registrar/General Manager

Chiropractic Board of New Zealand

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1 July 2019

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Email: SConsultation@mcnz.org.nz

Tēnā koutou,

Thank you for the opportunity to make a submission on the draft *Statement on cultural competence and the provision of culturally-safe care*, and the draft resource, *Achieving Best Health Outcomes for Māori*.

Family Planning strongly supports these documents and endorses them as valuable, not only to doctors, but to anyone working in the health and social services sectors.

About Family Planning

Family Planning is New Zealand's largest provider of sexual and reproductive health services and information. We are a non-governmental organisation (NGO) operating 30 clinics as well as school and community-based services. We provide about 154,000 clinical consultations each year to clients across the country. We offer accredited clinical courses and workshops for doctors, nurses, midwives and other clinicians working in sexual and reproductive health. Our health promotion teams run professional training and education programmes in schools and the community for children and young people, parents, teachers and other professionals. We employ doctors, nurses and nurse practitioners, health promoters and administrative staff.

Family Planning is committed to increasing health equity as a strategic priority, with a focus on improving Māori health and wellbeing. To achieve health equity, we have made a commitment to:

- prioritise and embed health equity into all areas of our work
- promote equitable access to services and deliver sexual and reproductive health and rights in the areas of highest need
- prioritise services to rangatahi Māori
- advocate for changes that will increase health equity, such as policies and practices to tackle social and economic determinants of ill-health including stigma, racism, disparities in educational achievement, violence and poverty.

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

- Family Planning appreciates the clear definition of cultural competence which is provided in point 14.
- Family Planning recommends adding a similar definition of cultural safety and culturally-safe care. While it can be assumed that cultural competence enables a doctor to provide culturally-safe care, it would be useful to state this explicitly and to include a simple definition.
- Family Planning welcomes and supports the cultural competence standards for doctors and reiterates that these standards would apply equally well to anyone working in the health and social services sectors.

Comments on the resource document, *Achieving Best Health Outcomes for Māori*.

- The Medical Council could consider rewording point 4 of the introduction. Health equity experts recommend stating what barriers and other factors contribute to health disparities prior to naming them, in order to be clear that the populations experiencing disparities are not to blame.

Point 4 could be restructured as follows: Due to inequity in determinants of health, access to health care and quality of health care provision, Māori experience disparities in outcomes compared to the rest of the population across nearly all areas of health.

- The wording of point 16 is slightly confusing as it is not clear what access “through” high-quality health services means.

- Point 24 could also recommend that doctors and healthcare organisations advocate for addressing the social determinants of health as a means to improve health outcomes for Māori.

In summary, Family Planning strongly supports the two consultation documents. Congratulations on developing such clear and useful statements on cultural competence and achieving best health outcomes for Māori.

Ngā mihi nui



Jackie Edmond
Chief Executive

18 June 2019

Dr Curtis Walker
Chair
Medical Council of New Zealand

Email: SConsultation@mcnz.org.nz



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Kia ora Dr Walker

The Health Quality & Safety Commission (the Commission) appreciates the opportunity to comment on Medical Council's 'Statement on cultural competence and the provision of culturally-safe care' and 'Achieving best health outcomes for Māori: a resource'.

I have discussed these documents with our executive leadership team and with Māori staff within the Commission. We all considered that these were some of the best statements on cultural-safety and cultural competence that we have seen. We congratulate the Medical Council and Te Ora on the work you have done to produce this draft.

We also welcome Council's 'Achieving best health outcomes for Māori: a resource' recognising Māori as tāngata whenua of Aotearoa and both clinician and organisational responsibilities to addressing Māori health advancement under Te Tiriti o Waitangi, and the United Nations Declaration on the Rights of Indigenous Peoples (2010).

Our discussion focussed on how the cultural competence standards can be embedded in the various Medical Colleges with the strengthened recertification focus and CPD programmes. We wondered if some common tools and resources available to all Colleges shared with other professional bodies might be useful in helping clinicians acquire the stated attitudes, knowledge and skills of cultural competence. Assessment of these again should be common across all professional groups and perhaps again some shared resources would be of help.

Further, we would be interested in considering any framework that Council may be devising to assist in the assessment of complaints of competence or conduct against these new standards.

The Commission would like to support Council in helping socialise 'Achieving best health outcomes for Māori: a resource' with organisations and all clinician groups, as well as looking at ways of promoting that the cultural competence standards are adopted by all working in healthcare.

Ngā mihi nui

A handwritten signature in black ink that reads "Janice Wilson".

Janice Wilson (Dr)
Chief Executive

10 July 2019

Tēnā koutou Medical Council of New Zealand,

CONSULTATION ON CULTURAL COMPETENCE, PARTNERSHIP AND EQUITY

Thank you for this opportunity to provide a formal submission on the statement on cultural competence and the provision of culturally safe care, and Achieving Best Health Outcomes for Māori: A resource.

This submission is a collective response from our team at the Māori/Indigenous Health Institute, Otago Medical School, University of Otago, Christchurch campus. We have been teaching the Hauora Māori curriculum since 2002, and make our comments based on this experience in medical education, working alongside the AMC accreditation process, and Medical Colleges.

Firstly, we commend the Medical Council for undertaking this pivotal piece of work, and we support the broader statement on cultural competence, with Hauora Māori competencies being documented in a separate document. We provide separate feedback, in brief, on both documents.

1. The Statement on cultural competence and the provision of culturally-safe care:
 - a. We agree with the purpose of the statement and Introductory comments under Statutory responsibilities.
 - b. Under the heading 'Health Equity' we suggest the re-ordering of the key points in this section. We would move point No. 12, to the top of this section. We suggest the wording be changed to "Evidence identifies that being socialised in a colonial society informs and maintains cultural bias. There is a need to identify and address how cultural bias influences systemic and clinical bias. There is a need for systemic response and clinical and cultural competencies to ensure all patients receive best practice health care.
 - c. Current No. 11 (under Health Equity): This language is 'othering' current literature uses the term 'intersectionality'. We suggest a more positive statement that is inclusive of this term e.g. "Council recognises cultural intersectionality, and that specific cultures can be a marker of being exposed to more risk factors than others which impact health equity. Developing culturally safe care and practice requires inclusivity of intersectionality.
 - d. Current No. 14: Change last sentence to "Council requires doctors to advocate for health care that reduces bias and promotes equity."
 - e. Current No. 15. Delete first sentence. Begin "In order for you ..."
 - f. We note "attitudes" are difficult to identify, amend and measure. However, the four items listed in this section actually refer to Professional development/self-awareness/cultural safety. We suggest Culturally safe practice may be considered more appropriate as a heading.
 - g. Under awareness and Knowledge. This is written from an 'othering' perspective. Given the growing diversity in cultural groups in medicine the language here needs to be amended to ensure it does not promote 'othering' or 'saving' (as opposed to working alongside) communities. We query if 'Attitudes' really about understanding your own

social-cultural influences, and how this informs bias? Then the second one is about skills needed to ensure you can navigate these biases to provide care for all patients, and be mindful of how you privilege those like you, and disadvantage those around you. Within the OMS our six learning outcomes for Cultural competency are:

- i. Describe how the health context is influenced by social and political agendas.
- ii. Describe how social and political agendas influence institutional, systemic and personal enablers and/or barriers within our society that maintain health privilege, health inequities and health disparities
- iii. Describe how experiencing institutional, systemic, interpersonal enablers and/or barriers effects patient health equity and health seeking behavior.
- iv. Demonstrate key knowledge, strategies and skills that could be used to navigate institutional, systemic and personal enablers/barriers to work toward health advancement for communities that experience inequity.
- v. Integrate critical frameworks that support cultural and clinical competence practice that contribute to increase positive patient health experiences and health advancement.
- vi. Demonstrate self-awareness and self-reflection skills including within the context of the 'culture of medicine' and its impact on clinical outcomes.

We believe the above language may be more advantageous for the Medical Council to use as they are 'inclusive' of all clinicians. We also think they are able to capture well the key points in Attitudes, awareness and knowledge and Skills in a more succinct way than is currently being listed. It also connects the relationship between clinical and cultural competency to health equity which we believe is the key intent of the medical Council.

2. Achieving Best Health Outcomes for Māori: a resource

- a. We agree with the purpose statement.
- b. Current No. 3 we would ask that the word 'special' is removed in this context it does not promote a clear political commitment. The Treaty should be included in this sentence, to clearly articulate indigenous rights.
- c. Current no. 8. We do not agree with this sentence. Nor do we believe it well aligns with the literature, and our own research.
- d. We think points 4-7 need to better link to evidence in health inequities.
- e. The Māori population section – please delete No.11 it unintentionally prioritises some regional areas over the other. This has no relevance to health equity or indigenous rights.
- f. Under Rational. We suggest changing the order – so Rights-based rationale is first, then Needs-based rationale.
- g. With rights based we ask you to consider linking to the following; human rights act, treaty partners and relationships with crown agents (including DHB) to iwi, and the role of patient audits in this space.
- h. Our concern with the needs-based rationale is that there is no reflection or framing of systemic barriers including colonisation and racism as causation factors to health inequities – and how these two processes continue to maintain inequitable health outcomes. There is ample data within DHB and PHO to drive best practice/evidence pathways that would support equity. We think a focus on equity and best practice would strengthen this document and engage the membership.
- i. We do not think there needs to be detailed explaining of specific health outcomes, as this is well documented in the literature and again tells the story, but doesn't coach members as to expectations of them. We believe this should be the purpose of the document. How do all doctors strive for best health outcomes for Māori? Within our curriculum we have clear guidelines to support our students using eight learning

outcomes. We believe the following learning outcomes would also support those affiliated with the MCNZ.

- i. Demonstrate their knowledge of Te Ao Māori and Māori health models and its role in supporting Māori health advancement. (*Te Ao Māori*)
- ii. Identify and describe the role of the Treaty of Waitangi in maintaining indigenous health rights for Māori in Aotearoa/New Zealand and in contributing to Māori health advancement. (*Treaty of Waitangi*)
- iii. Demonstrate competence and confidence in utilising te reo Māori with Māori patients, whanau, community and other rōpū Māori and identify its role in Māori health advancement. (*Te Reo Māori*)
- iv. Demonstrate knowledge of current health status, the determinants of health and the mechanisms that create and maintain health inequities for Māori. (*Determinants of health equity*)
- v. Demonstrate an ability to undertake the critical appraisal of health research utilising tools that challenge how knowledge paradigms can manifest within health systems and professional practice that impact on Māori health advancement. (*Critical analysis*)
- vi. Describe, demonstrate and reflect on their interaction with Māori patients and whanau utilising Māori health models/concepts/approaches in tandem with appropriate clinical models, in order to support Māori health advancement. (*Clinical skills*)
- vii. Demonstrate the ability to critically analyse the health system and health service gaps on a clinical presentation, service delivery and Māori health advancement. (*Systems that impact Māori health outcomes*)
- viii. Identify and participate in opportunities that intervene to promote Māori health advancement. (*Systems that impact Māori health*)
- j. We think competency driven goals will make sense to members of the MCNZ, and support the measuring of these outcomes.
- k. Under Guidance for doctors and healthcare organisations, we think this section would be supported by link to specific resources that are available to support members. We would also like to see the inclusion of Medical Colleges placed within this document to provide a level of accountability within those organisations.
- l. We also believe there needs to be a focus on 'clinical competency and safety' as a prerequisite to working with Māori to ensure equitable health care.

We hope these comments are helpful in your ongoing process to refine these documents. Again we are excited by the movement by the MCNZ to identify the role of cultural competence in supporting health equity, and a specific response to Māori.

We are happy to be contacted if further clarification of our submission is required.

Ngā mihi mahana,

The MIHI team, UOC

Associate Professor Suzanne Pitama, Dr Cameron Lacey, Tania Huria, Dr Maia Melbourne-Wilcox
Dr Maira Patu, Dr Courtney Thomas and Dr Angela Beard

2 July 2019

Medical Council of New Zealand
Email: SConsultation@mcnz.org.nz

Dear Sir/Madam

Consultation on Cultural Competence, Partnership and Health Equity

I am writing to provide you with feedback from the Ministry of Health (the Ministry) about your revised draft documents for consultation:

- *Statement on cultural competence and the provision of culturally-safe care*
- *Achieving best health outcomes for Māori: a resource*

The Ministry considers these documents to be comprehensive and well written. We agree with the proposed definition of cultural competence and cultural competence standards expected of doctors. We also agree with the guidance for doctors and health care organisations that you have provided with regards to supporting the achievement of Māori health equity. We see no reason to modify either of these documents.

Thank you for the opportunity of reviewing the documents and providing you with feedback about them.

Yours sincerely



Dr Juliet Rumball-Smith
Acting Chief Medical Officer



5 July 2019

Submission to the Medical Council of New Zealand

Cultural Competence, Partnership and Health Equity – Consultation on Revised Documents

The New Zealand College of Public Health Medicine would like to thank the Medical Council of New Zealand (the Council) for the opportunity to provide feedback on the revised statements *Statement on cultural competence and the provision of culturally-safe care* and *Achieving best health outcomes for Māori: a resource*.

The New Zealand College of Public Health Medicine (the College) is the professional body representing the medical specialty of public health medicine in New Zealand. We have 222 members, all of whom are medical doctors, including 185 fully qualified Public Health Medicine Specialists with the majority of the remainder being registrars training in the specialty of public health medicine.

Public Health Medicine is the branch of medicine concerned with the assessment of population health and health care needs, the development of policy and strategy, health promotion, the control and prevention of disease, and the organisation of services. The NZCPHM partners to achieve health gain and equity for our population, reducing inequalities across socioeconomic and cultural groups, and promoting environments in which everyone can be healthy.

Background

The College recognises that compelling health inequities exist in New Zealand between Māori and non-Māori New Zealanders.¹ These inequities are large, pervasive, and persist across the lifespan and over time. Maori also experience a differential level of healthcare which contributes to already poor health outcomes in these groups.^{2,3,4} The College is committed to a vision of a fair and just society where Māori and non-Māori have equitable health outcomes.⁵

We therefore support the Council in its mahi to strengthen the standards for doctors regarding the provision of culturally safe care.

General Comments

The College agrees with the Council that concepts evolve over time, and that a review of the Council's *Statement on cultural competence* is appropriate at this time.

We strongly support the adoption of a definition of cultural competence that focuses on critical consciousness, self-reflection and self-awareness, rather than on acquisition of knowledge about other cultures.

We consider that the Council could go further in embracing the concept and nomenclature of 'cultural safety': to the extent that the concept of cultural safety surpasses and incorporates that of cultural competence, we can see no reason why the specific use of the term 'cultural competence' in the Health Practitioners Competence Assurance Act (2003) should prevent the Council adopting the more suitable term.

We commend the Council for including a section on health equity in the revised Statement. We suggest

that the document could go further in specifying the need to attain health equity as a primary rationale for cultural competence / safety requirements.

Consultation Questions

Draft 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?

Traditional understandings of cultural competence have taken a narrow approach in encouraging health professionals to learn about the cultural practices, beliefs and values of other ethnic groups.⁶ The College recognises that there are dangers in adopting this simplistic approach: these include stereotyping and ‘othering’, and ignoring power differentials.^{6,7}

The College supports the incorporation of the concept of cultural safety in the proposed definition. This extends beyond simply learning about cultural mores and requires ‘safe service’ to be defined by those who receive it. It is underpinned by the concept of critical consciousness, requiring doctors to reflect on their own assumptions, biases and values, shifting the gaze from self to others and to injustice in the world.^{6,8} This reflexive analysis should acknowledge diversity in worldviews and include an understanding of how culture, values, norms and behaviours may affect interactions with others. Cultural safety also requires providers to undertake an analysis of the institutional and personal power relations operating in the context, and to negotiate power imbalances to ensure patients receive equitable and acceptable care.⁶

We note that the first line of the definition reads “*The requirement for doctors to examine the potential impact of their and their patients’ culture on clinical interactions and healthcare service delivery*”. We suggest that this line could be strengthened to include the requirement for doctors to ‘*examine the potential impact of their own culture, including biases, attitudes and assumptions, on healthcare and service delivery*’.

We note that the proposed definition has a strong focus on the practice of individual doctors. This is understandable in terms of Council’s role in regulating individual practice. However, since healthcare organisations play a key role in determining the systems and structures which either promote or prevent inequities in health outcomes, we suggest the inclusion of a responsibility for doctors to contribute towards the development of culturally-safe organisations.⁹

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?

The College agrees with the proposed wording changes and amendments in paragraph 15. We support the use of strengthened language to describe the Council’s expectations with regard to the provision of culturally safe care.

In particular, we strongly support the proposal to replace the following words/phrases:

- 15. a. i. *willingness* with *responsibility*
- 15. a. iii. *preparedness* with *commitment*
- 15. a. iv. *willingness* with *responsibility*

15. b. ii. *awareness with acknowledgement*

15. b. iv. *understanding with respect*

15. c. i. *rapport with connections*

15. c. ii. *cultural issues with cultural factors important to the patient*

15. c. iii. *Use cultural information when making a diagnosis with Use cultural information and cultural differences when developing a diagnosis and formulating a treatment plan that responds to both the cultural preferences of the patient and 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.*

The College strongly support the inclusion of an equity rationale in the Statement and supports the Council's use of the Ministry of Health's definition of equity.¹⁰ We further strongly support the acknowledgement of the principles of te Tiriti o Waitangi and recognition of the indigenous rights of Māori as key drivers behind the *Statement on cultural competence and the provision of culturally-safe care*.

The College considers the health equity rationale for cultural competency and culturally-safe care should refer also to Pacific peoples. In New Zealand, Pacific peoples are over-represented in poor health outcomes and health inequities^{11, 12} and like Māori, receive a differential level of healthcare to non-Māori and non-Pacific people.^{13, 14} There is compelling evidence that although Pacific people access the health system, have high enrolment rates with Primary Health Organisations, and have high attendance rates with General Practitioners, they do not achieve the same health outcomes as other groups.¹⁵ As a Pacific nation, New Zealand has a responsibility to its region and to all Pacific peoples living in New Zealand. We suggest that, in the section on health equity, the Council also recognises this responsibility and the need to address inequities in health outcomes for Pacific peoples.

We note that the Statement provides standards for doctors in providing culturally-safe care to patients and their families/whānau. We suggest that these standards should apply also to doctors in their other professional roles: as leaders, managers, teachers and advocates.

Draft Achieving Best Health Outcomes for Māori: a Resource

4. Paragraph 27 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? and

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

The College supports the revisions to the document previously titled *Statement on best practices when providing care to Māori patients and their whānau*. The new *Achieving best health outcomes for Māori: a resource* is consistent with the new *Statement on cultural competence and the provision of culturally-safe care* in taking the focus off cultural differences, and placing it onto critical consciousness, self-reflection and self-awareness.

We support the arguments set out for the rationale for addressing Māori health. The College is committed to a vision of a fair and just society where Māori and non-Māori have equitable health outcomes, and recognises that Māori, as the indigenous people of Aotearoa New Zealand, have unique rights under te Tiriti o Waitangi (the Treaty of Waitangi) and the United Nations Declaration on the Rights of Indigenous Peoples.⁴

The College supports the suggestions included in the section on *Guidance for doctors and healthcare organisations to support achieving Māori health equity* as providing useful information that can help doctors and their healthcare organisations in critical self-reflection processes. We note this is in paragraph 24 of the draft Resource document (not paragraph 27, which we cannot find), which states:

“Guidance for doctors and healthcare organisations to support achieving Māori health equity

24. Doctors and their associated healthcare organisations can support Māori health equity by:

- a. Demonstrating an awareness of Māori indigenous rights and current issues in relation to health and health equity.
- b. Responding to the Treaty-based requirement to deliver effective healthcare to Māori.
- c. Supporting healthcare organisations to formally identify and address structures and processes that limit Māori health development.
- d. Proactively develop policies to improve Māori participation and success at all levels.
- e. Engaging in, and showing evidence of transformation with respect to, culturally-safe practice that aligns to the Council’s Statement on Cultural competence and the provision of culturally-safe care.”

However, we suggest that 24.a. could be better framed as two points:

- Demonstrating a commitment to Māori indigenous rights and te Tiriti o Waitangi obligations; and
- Demonstrating a thorough awareness of issues in relation to health inequities in general, and specifically with regard to health inequities in the area of the doctor or health organisation’s practice.

Furthermore, the College considers that the medical profession can better support Māori health equity by also engaging Māori health organisations, governance groups and representative committees when inputting into public policy changes/development that may affect Māori; and (where welcome) by supporting Māori health organisations, governance groups and representative committee’s own efforts into policy input. This extends beyond individual practitioners and healthcare organisations, to include wider professional bodies – giving a clear role for Colleges, the Council and other organisations. In this context, the wording “healthcare organisations” would be better as “health organisations”.

We therefore recommend the wording for paragraph 24 be amended to (with changes in ~~strikethrough~~ and **yellow highlights**):

Guidance for doctors and healthcare organisations to support achieving Māori health equity

24. Doctors and their associated **professional bodies** and healthcare organisations can support Māori health equity by:

~~a. Demonstrating an awareness of Māori indigenous rights and current issues in relation to health and health equity.~~

a. Demonstrating a commitment to Māori indigenous rights and te Tiriti o Waitangi obligations.

[new]. b. Demonstrating a thorough awareness of issues in relation to health inequalities in general, and specifically with regard to health inequities in the area of the doctor or health organisation’s practice.

[renumbered] c. Responding to the Treaty-based requirement to deliver effective healthcare to Māori.

[renumbered] d. Supporting healthcare organisations to formally identify and address structures and processes that limit Māori health development.

[renumbered] e. Proactively develop policies to improve Māori participation and success at all levels.

[renumbered] f. Engaging in, and showing evidence of transformation with respect to, culturally-safe practice that aligns ~~to~~with the Council's *Statement on cultural competence and the provision of culturally-safe care*.

[new] g. Engaging Māori health organisations, governance groups and representative committees for input into public policy changes and development that may affect Māori.

[new] h. Supporting, as appropriate and asked for, Māori health organisations', governance groups' and representative committees' own efforts with public policy development that may affect Māori.

We also recommend tidying the references in this document, for example, with reference 1, World Health Organisation should be spelt with a 'z' as World Health Organization; with reference 13, "U. Nations, Editor" should be "United Nations".

Thank you for the opportunity for the NZCPHM to submit on the revised statements for consultation; *Statement on cultural competence and the provision of culturally-safe care* and *Achieving best health outcomes for Māori: a resource*. We hope our feedback is helpful and are happy to provide further clarification on matter covered in this submission.

Sincerely,



Dr Felicity Dumble, President, NZCPHM

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Rachael Crombie

From: Adrian Metcalfe (RNZCUC)
Sent: Tuesday, 9 July 2019 4:56 p.m.
To: Strategic Consultation
Subject: FW: MCNZ Consultation - cultural competence, partnership and health equity

Categories: Green Category

Tēnā koe,

Thank you for the opportunity to comment on the draft statements.

RNZCUC position is to align with Council's policies, standards, and procedures. Thus our comments are minor. We've provided our responses within the requested template.

A minor comment is the spelling of the word 'focused'. It is spelt differently in the two documents (focused, focussed), and a recommendation is to decide on one format.

Draft 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?

In the following statement:

Council requires doctors to influence healthcare to reduce bias and promote equity.

The term "influence healthcare" seems unbounded. Is this the care that the doctor provides? The clinic? The organisation? PHO? Policy makers?

What evidence would Council require for the doctor to demonstrate they are doing this?

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?

The notion of self-reflection is embedded within two higher-level statements (Awareness and Knowledge, Skills). This is an important aspect of cultural safety (cultural competence in Council's definition). Council may wish to consider placing these as a separate aspect under Awareness and Knowledge. Suggested text is:

vii. Continuously reflect upon, and address deficiencies in, your knowledge, skills, and practices that contribute to culturally safe care.

viii. Reflect on sources and determinants of inequities.

Paragraph c – Skills. The text (*Cultural competence requires you to reflect on sources and determinants of inequities and to implement reflective practice that demonstrates the ability to:*) seems to wrap 'demonstration' within 'self-reflection'. We understand the principle and intention, but it seems to lose its focus.

We recommend adding the additional bullet point to Awareness and Knowledge (viii above), and change the text to:

Cultural competence requires you to demonstrate that you have developed specific skills, and to reflect on how well you use those skills within your practice to provide a culturally safe environment".

There is a risk of inadvertently causing offence, despite our best intentions. It may be useful to require an additional skill required in this section on how to respond when this happens. Suggested text is:

ix. Respond appropriately when invited to modify one's approach to provide culturally appropriate care.

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.

No additional feedback.

Draft Achieving best health outcomes for Māori: a resource 4.

Paragraph 27 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?

Paragraph 24? We believe this adequately captures the key points.

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

This is an excellent guide for Colleges and doctors.

Ngā mihi nui,
Adrian



RNZCUC
ROYAL NEW ZEALAND COLLEGE OF URGENT CARE

Adrian Metcalfe

General Manager

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2 July 2019

Joan Simeon
Chief Executive
Medical Council of New Zealand

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

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 associated professional bodies 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 Organization. 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

A handwritten signature in blue ink that reads "K. Baddock". The signature is written in a cursive style with a large, sweeping flourish at the end.

Dr Kate Baddock
NZMA Chair

#33

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Tuesday, July 09, 2019 4:26:17 PM
Last Modified: Tuesday, July 09, 2019 5:16:56 PM
Time Spent: 00:50:39
IP Address: 203.97.25.6

Page 1: Statement on cultural competence and the provision of culturally-safe care

Q1 Do you agree with the proposed definition of cultural competence?(see paragraph 14 of the draft Statement on cultural competence and the provision of culturally-safe care)

No,
Do you have any suggestions on how the draft definition could be improved?:
Many internationally trained doctors need to reflect bicultural rather than multicultural competence in an Aotearoa New Zealand setting. The Council cultural competence definition needs to clarify this by including: reference to Aotearoa New Zealand's bi-cultural history and setting where health care services are delivered, service delivery needs to reflect both the patients and their whanau , who are currently not being included. opening statement should reflect doctors attitude to patients and their whanau which is under attitudes section but not included in definition.

Q2 Do you agree with the proposed standards outlined in paragraph 15 of the draft Statement on cultural competence and the provision of culturally-safe care?

No,
What changes (if any) do you suggest could improve these draft standards?:
In general: A stronger commitment to the articles of te Tiriti o Waitangi and Multiculturalism is required (see Waitangi Tribunal Kaupapa Maori inquiry recommendations for health sector change); Consistency in language - whanau are not always included with the patient in the bullet points; Under attitudes: Stronger wording is required (than "a commitment") to ensure attitude and practice change; Under skills: Demonstrating cultural competency through use of Te Reo Maori is missing from skills lists.

Q3 Do you have any other feedback about the draft Statement on cultural competence and the provision of culturally-safe care that you think Council should consider?

Yes:
Language needs to be clear with the use of plain English. We agree with the use of the MOH health equity definition, for consistency across the health workforce.

Page 2: Achieving best health outcomes for Māori: a resource

Q4 Paragraph 24 of the draft Achieving best health outcomes for Māori: a resource, 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?

No,
What changes (if any) do you suggest could improve this guidance?:
Consistency of language use of Maori or indigenous in document. Needs to reflect and use te Tiriti o Waitangi articles rather Treaty based, that gives a different context to Maori and Tangata whenua. What cultural competency training does the MCNZ offer members?

Q5 Do you have any other feedback about the draft Achieving best health outcomes for Māori: a resource that you think Council should consider?

Yes:
Section 19 needs to be updated to reflect te Tiriti o Waitangi articles - Kawanatanga, Tino rangatiratanga, and Oritetanga. as the Treaty principles are outdated and no longer used.

Page 3: Submission Information

Q6 Your information

Name

Leanne Manson

Organisation

New Zealand Nurses Organisation

Email address

leanne.manson@nzno.org.nz

Q7 Your role/title

Policy Analyst Maori

Q8 This submission is on behalf of:

An organisation

Q9 I wish for my submission:

To be published as identified



11 July 2019

Joan Simeon
Chief Executive
Medical Council of New Zealand
Email: SConsultation@mcnz.org.nz

Dear Joan,

Re: Medical Council of New Zealand's draft revised statements on Cultural Competence and Best practices when providing care to Māori patients and their whānau.

The New Zealand Society of Anaesthetists (NZSA) welcomes the opportunity to provide feedback on the above MCNZ consultations.

About the New Zealand Society of Anaesthetists

The NZSA is a professional medical education society, which represents over 650 medical anaesthetists in New Zealand. Our members include specialist anaesthetists in public and private practice, and trainee anaesthetists. We facilitate and promote education and research into anaesthesia and advocate for our members and the safety of their patients. As an advocacy organisation we develop submissions, work with key stakeholders, and foster networks of anaesthetists nationwide. The NZSA, established in 1948, also has strong global connections, and is a member of the Society of the World Federation of Societies of Anaesthesiologists (WFSA).

Comments

The NZSA is very supportive of MCNZ's revised statements and concurs with MCNZ's view that by further improving the cultural competence of the workforce it will create greater health equity and improve health outcomes for all cultural groups, including Māori as tāngata whenua.

The Statement on cultural competence clearly outlines the standards and expectations of cultural competence for doctors, and it is appropriate that the onus is on the doctor to be responsible for their practice. It provides a strong guideline for doctors to reflect on and strengthen their practice as it relates to cultural safety and competence.

We are supportive of the recommendation made by the New Zealand Medical Association in its submission that professional bodies be added to paragraph 24, to include professional associations/societies. This would clearly indicate the role of organisations, such as the NZSA, to support Māori health equity. The amended wording they suggest is: "*Doctors and their associated professional bodies and healthcare organisations can support Māori health equity by:*"

Thank you for the opportunity to comment.

Yours sincerely

A handwritten signature in black ink, appearing to read "Kathryn Hagen", with a long horizontal line extending to the right.

Dr Kathryn Hagen
President

10 July 2019

Submission to the Medical Council of New Zealand: Cultural Competence, Partnership and Health Equity – Consultation on Revised Documents

Thank you for the opportunity to provide feedback to the review of the Council's existing statements on *Cultural Competence and Best practices when providing care to Māori patients and their whānau*, which is being undertaken in partnership with Te Ohu Rata O Aotearoa (Te ORA).

Context for PHARMAC's submission

PHARMAC's role within the New Zealand health system is to make decisions on which medicines and medical devices are funded in order to get the best health outcomes from within the available funding. We also promote the responsible use of medicines in New Zealand, making sure medicines are not under-used, over-used or misused. We therefore have a strong interest in the competence standards for prescribing clinicians, including doctors.

PHARMAC has a strategic goal of eliminating inequitable access to medicines. In our recent publication *Achieving medicine access equity in Aotearoa New Zealand: towards a theory of change*¹ we have identified five primary drivers for change to eliminate these inequities, which are:

- Availability – how PHARMAC makes and implements funding decisions so that everyone who is eligible can access funded medicines
- Affordability – reducing cost barriers so that people can afford funded medicines
- Accessibility – ensuring people don't face challenges getting to see a prescriber or to the pharmacy
- Acceptability – the ability of health services to create trust, so patients are informed and engaged enough to accept the medicines they've been prescribed
- Appropriateness – the adequacy and quality of prescribing to ensure equitable health outcomes.

¹ PHARMAC. *Achieving Medicine Access Equity in Aotearoa New Zealand: Towards a Theory of Change* (April 2019) <https://www.pharmac.govt.nz/assets/achieving-medicine-access-equity-in-aotearoa-new-zealand-towards-a-theory-of-change.pdf>

The report identifies a considerable body of New Zealand research that points to inequities by ethnicity in dispensing patterns for community medicines², a portion of which is likely to arise from unwarranted variation in prescribing and implicit bias from clinicians. We note that prescriber competence (including cultural dimensions) are linked to the Acceptability and Appropriateness drivers for equitable access to medicines. Culturally-safe prescribing and medicines optimisation are therefore key aspects of the provision of culturally-safe care and the achievement of equitable health outcomes overall.

Overall feedback on both documents

The Medical Council of NZ is the regulatory authority of medical practitioners and is responsible for administering the intention of the Health Practitioners Competence Assurance Act 2003 for the profession of medicine. The purpose of the Act is to protect the health and safety of the public, and responsible authorities fulfil that purpose by ensuring all health practitioners registered with them are fully competent in the practice of their profession.

We are very supportive of strengthened standards for doctors for the provision of culturally-safe care. In addition to consulting on the documents themselves, it would have been useful to have some information on the mechanisms Council is proposing to monitor the meeting of these standards and expectations by registered doctors. We would expect to see that the monitoring mechanisms put in place to enable culturally competent and culturally safe practice are co-design with patients as well as informed by engaging with Māori.

Further, audit of clinical practice (including of prescribing) is one likely means of measuring whether culturally-safe practice is leading to equitable access and health outcomes. Given PHARMAC's extensive familiarity with Aotearoa New Zealand's pharmaceutical data, and partnership with BPACnz to produce prescriber reports and audits, there may be value in discussing approaches and methods with us.

Response to discussion questions

Draft 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 proposed definition could be strengthened by indicating that cultural competence is a personal commitment and characteristic of being lifelong learners as health professionals, as with any and all medical competencies.

The definition could be strengthened and made more patient-centred by articulating the implications of culturally-safe practice for i) all patients and ii) for Māori health outcomes. For the former, the implication of the definition could be that 'all patients should experience a culturally- safe environment as a result of the practice of the doctors'.

For the latter, the implication could be articulated along the lines that 'Māori should have a fair opportunity to attain their full health potential, and that Māori should not be disadvantaged from achieving this potential because of the culturally incompetent and

² See, for example, Te Karu L, Bryant L, Harwood M, Arroll B. Achieving health equity in Aotearoa New Zealand: the contribution of medicines optimisation. J Prim Health Care 2018;10:11-15. Available from: <https://doi.org/10.1071/HC17067>

culturally unsafe practice of doctors'. The Treaty identifies, articulates and guarantees these rights for Māori. We believe that the addition of this will strengthen Council's position on what they expect from doctors to support the achievement of equitable health outcomes for Māori and will complement the other document being consulted on.

We also suggest strengthening the language in the final sentence of paragraph 14 on the promotion of equity and to link it more closely to paragraph 9, emphasising that equity requires different approaches and the investment of more effort and resource in those populations experiencing disadvantage.

Finally, we note that the terminology of 'cultural competence' is itself contested, with experts expressing concern that the term inadequately captures the transformation of practice required, with those experts preferring the term 'cultural safety' instead. We recognise that the term 'cultural competence' has been used by the Council in order to align with the wording in the Health Practitioners Competency Act, however we contend that there is nothing stopping the Council from defining a standard that is higher than that contemplated by the Act. Rather than redefining 'cultural competence' to be more in line with concepts of 'cultural safety', we suggest that the Statement be renamed 'Statement on the provision of culturally-safe care' and includes a definition of 'culturally-safe care' that supersedes 'cultural competence'. See our response to the following question for further expansion.

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?*

Overall comments on the construct of the standards

While the construction of the competence standards is based on the usual definition and components of what competence is, ie attitudes, awareness and knowledge and skills, it is not entirely clear how this construct as stated will actually result in changed practice. In particular, the Skills section may not give doctors (and Colleges, in the development of appropriate education and training programmes) sufficient direction on how culturally-safe practice can be applied, and to ensure patients feel culturally safe in their interactions with them.

For example, for Māori and Pacific island populations a culturally-safe interaction would involve exploring all the dimensions they viewed as being important to health i.e. taha wairua (the spiritual), taha tinana (the physical), taha whānau (the family) and taha hinengaro (the mind). It may also include their taiao (physical environment) and connection to their whenua (land). In this regard, the physical symptoms are often seen by them as manifestations of what is happening in the other dimensions, and doctors can be more caring and effective if they help the people connect these together. Being culturally safe could also include knowing the significance of karakia and prayer with regards to health (including, but not specific to Māori whānau and Pacific Island communities) and creating space for this to occur during a consultation or after delivering the news of a diagnosis, prognosis or starting lifelong medicines. In the case of karakia and prayer, it is not necessary for the doctor to do this, but it would be expected that they are able to initiate this and organise for the most appropriate person to support the patient.

Contemporary Māori and Pacific health models (Te Whare Tapa Whā) distinguish the spiritual dimension of the person providing life to the physical and mental dimensions. This is reflected in the view of health as being holistic and based on whānau/family values. These cultural understandings need to be understood and applied to their practice by doctors when assessing the health need of these diverse peoples.

Application of Te Tiriti as a key aspect of culturally safe-practice also needs to be strengthened throughout the standards. Examples could include: the attitude of the doctor towards Te Tiriti o Waitangi/ The Treaty of Waitangi and its expression in their practice; the awareness and knowledge of how inequities in Māori health outcomes have arisen and an understanding of the evidence of the impact of institutional racism in health and wider systems on Māori; and the ability to demonstrate the skills that speak to restoring and promoting mana, tino rangatiratanga and manaakitanga of the people they look after.

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.*

Overall, we find the proposed statement to be not entirely adequate. We feel that the vocabulary used makes the whole statement too passive, and risks ambiguity. In the revision of the standard, the Medical Council and Te ORA can drive home the cultural competency/cultural safety message to doctors by using language that is direct, isn't ambiguous and states their responsibility clearly.

We make the following more specific suggestions:

- **Attitudes**

- Consider the addition of attitudes of **both humility and personal lifelong commitment**

- **Awareness and knowledge**

- Consider the addition of awareness and knowledge of the social determinants of health and their impact on health equity and
- Point iii could acknowledge that cultural factors also influence worldviews and cognitive models of health and wellbeing (beyond a health/illness paradigm)
- Point iv could include some examples, such as the significance of karakia and prayer.

- **Skills**

- The additions suggested under awareness and knowledge will support the skills listed in the proposal.

The use of Te Tiriti o Waitangi/The Treaty of Waitangi needs to be consistent across all documents.

Draft Achieving best health outcomes for Māori: a resource

4. *Paragraph 27 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?*

As Paragraph 27 is missing we have assumed that paragraph 24 was meant here.

Our feedback on this is similar to the Standard – our preference would be for more active language, with clear definitions. We also consider that this section needs to be considerably further developed in order to be of practical use.

We also note that the guidance on paragraph 24 is pitched at both doctors and health organisations, yet these are two separate audiences. The document needs to make it clearer when the guidance is aimed at doctors, health organisations or both. Further, we suggest that the guidance is clear that different actions and strategies can be employed at different levels, for example doctors who hold leadership positions of influence as clinical directors, chairs and members of clinical governance committees, alliance leadership teams and PHOs will have different leverage and strategies available to them compared to the individual clinician.

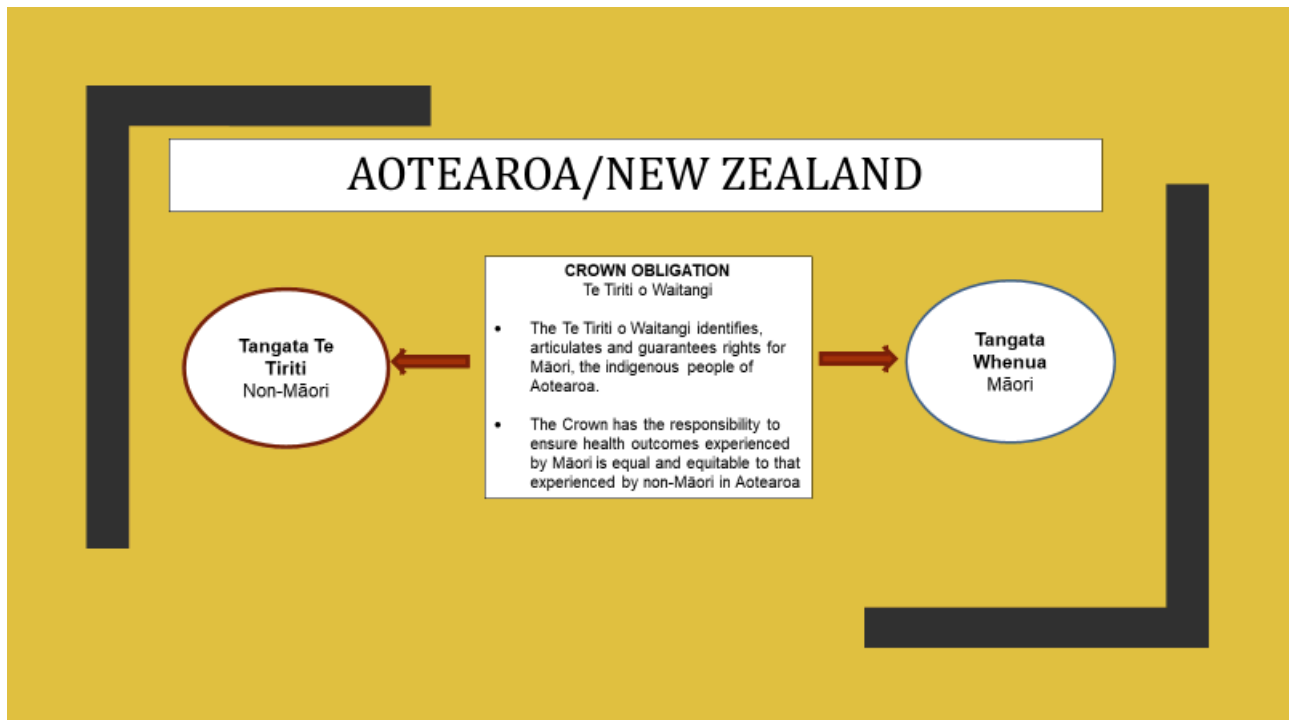
It would be useful to know how the Council plans to use this and what the doctors will do with it. It could include some next steps with regards to recommended reading, video presentations or contacting key Māori academics etc.

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

We think that the guidance provided for doctors and health organisations could be further developed. Currently, the guidance document presents high-level pathways that doctors and health organisations could incorporate into their clinical activity. These pathways range from demonstrating an awareness of Māori indigenous rights in relation to health and equity, to proactively developing policies to improve Māori participation and success. Given that the document is meant as a resource for both doctors and health organisations to improve their cultural competence, we think it would be more useful for the guidance document to include a toolkit of resources (eg, weblinks, templates, case studies).

Having a toolkit would make it easier for health organisations to understand, and potentially provide benchmarks for how doctors undertake cultural competency in their clinical work. There may be an opportunity to involve PHARMAC (and other agencies) in the development of such a toolkit, for example, the development of evidence-based guidance for culturally-safe prescribing.

We have made some suggestions below that relate to the specific sections of the resource. However, we think that the resource could be strengthened and significantly impactful if it was able build on the relationship of the te Tiriti o Waitangi with Māori as tangata whenua, the Crown, and non-Māori as tangata Tiriti. The figure below may be helpful to include as a foundation for the narrative in the resource.



Specific suggestions for the proposed resource

- *Introduction*
 - The resource needs to recognise that Māori as a population are not a homogenous group/population. Highlight the importance of tribal/iwi affiliations, whakapapa and the impact of settlement commitments on health etc.
 - Doctors should be familiar with what is impacting on local iwi and have a sense of the iwi groups around the area they are serving.
- *Rationale*
 - We suggest that the rights based rationale should come before the needs based rationale in the document.
 - The document could supplement the rationale section with the Stage 1 findings of Wai 2575 Health Services and Outcomes Kaupapa Inquiry.
- *Guidance for doctors and healthcare organisations to support achieving Māori health equity*
 - The evidence base for these recommendations is unclear and not in line with internationally published strategies for achieving health equity
 - For healthcare organisations, good guidance has been published by the Institute of Healthcare Improvement [Achieving health equity : a guide for health care organisations](#)
 - Recommended actions may be better divided into sections such as:
 - Individual/Clinical Level
 - Practice Setting Level
 - Systems Level.

Thank you once again for the opportunity to provide comment on this important mahi. We hope this feedback is useful and would be happy to further discuss any aspect of this submission.

Yours sincerely

A handwritten signature in cursive script, appearing to read "Alison Hill".

Alison Hill
Director, Engagement and Implementation

#36

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Friday, July 12, 2019 3:50:22 PM
Last Modified: Friday, July 12, 2019 3:54:13 PM
Time Spent: 00:03:51
IP Address: 219.89.117.61

Page 1: Statement on cultural competence and the provision of culturally-safe care

Q1 Do you agree with the proposed definition of cultural competence?(see paragraph 14 of the draft Statement on cultural competence and the provision of culturally-safe care) **Yes**

Q2 Do you agree with the proposed standards outlined in paragraph 15 of the draft Statement on cultural competence and the provision of culturally-safe care? **Yes**

Q3 Do you have any other feedback about the draft Statement on cultural competence and the provision of culturally-safe care that you think Council should consider? **No**

Page 2: Achieving best health outcomes for Māori: a resource

Q4 Paragraph 24 of the draft Achieving best health outcomes for Māori: a resource, 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? **Yes**

Q5 Do you have any other feedback about the draft Achieving best health outcomes for Māori: a resource that you think Council should consider? **Yes:**
Consider having compulsory Treaty of Waitangi training and understanding of Whaanau Ora Frameworks as part of ongoing workforce development.

Page 3: Submission Information

Q6 Your information

Name	Lance Norman
Organisation	ProCare Health Limited
Email address	lance.norman@procare.co.nz

Q7 Your role/title

Head of Equity and Maaori Health Outcomes

Q8 This submission is on behalf of:

An organisation

Q9 I wish for my submission:

To be published as identified

10 July 2019

Dr Curtis Walker
Chairperson
The Medical Council of New Zealand
Te Kaunihera
Rata o
Aotearoa

Dear Dr Walker

RE CONSULTATION

Reviewing the existing statements on: Cultural Competence and Best Practices when providing care to Māori patients' and their whanau in partnership with Te Ohu Rata O Aotearoa (Te ORA).

The Royal Australasian College of Medical Administrators (RACMA) is a specialist medical college accredited by the Australian Medical Council (AMC) and is dedicated to the education, training and professional development of medical practitioners in senior leadership, management and administrative roles, in clinical and non-clinical settings, throughout the world.

This constantly evolving fellowship and professional development program responds and pre-emptes the ever changing landscape of medical administration both in Australasia and beyond. RACMA's involvement in education, policy formulation and decision-making enables it to help contribute to the Australian and New Zealand Health systems.

RACMA appreciates the opportunity to comment on the Medical Council's 'Statement on cultural competence and the provision of culturally-safe care' and 'Achieving best health outcomes for Māori: a resource'.

RACMA would like to congratulate the Medical Council and Te Ora for these cultural competence standards for our New Zealand Fellows Associates, Affiliates and candidates in training. We also welcome Council's 'Achieving best health outcomes for Māori: a resource' recognising Māori as tāngata whenua of Aotearoa and both clinician and organisational responsibilities to addressing Māori health advancement under Te Tiriti o Waitangi, and the United Nations Declaration on the Rights of Indigenous Peoples (2010). We support the increased emphasis on Cultural Safety as an evolution from the attainment of Cultural Competence.



RACMA will focus on how the standards once finalised, can be embedded in our education programs encompassing our Fellowship and Leadership for Clinicians program, as well as our strengthened recertification focus and CPD programs.

RACMA would welcome the opportunity to work with other Colleges in developing tools, and resources to assist in working to creating meaningful learning and creating cultural safe practitioners to assist in improving the health outcomes of Māori people.

RACMA will socialise 'Achieving best health outcomes for Māori: a resource' with all of our members once the document is finalised.

Again, RACMA welcomes this initiative, the workshops being provided to Colleges and look forward to working collaboratively with other Colleges and our members in this important work.

Yours faithfully

Iwona Stolarek

Dr Iwona Stolarek
Vice President



10 July 2019

Kanny Ooi
Senior Policy Adviser and Researcher
Medical Council of New Zealand
Email: sconsultation@mcnz.org.nz

Dear Kanny

Thank you for the opportunity to give feedback on the two documents: the revised *Statement on Cultural Competence and the Provision of Culturally Safe Care*; and *Achieving Best Health Outcomes for Māori – a Resource*, produced by the Medical Council in collaboration with Te Ohu Rata o Aotearoa.

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in New Zealand. We are a not-for-profit organisation with more than 7000 surgeons and 1300 surgical trainees and International Medical Graduates in New Zealand and Australia as members. RACS represents nine surgical specialties, these being Cardiothoracic Surgery, General Surgery, Neurosurgery, Orthopaedic Surgery, Otolaryngology Head-and-Neck Surgery, Paediatric Surgery, Plastic and Reconstructive Surgery, Urology and Vascular Surgery.

RACS is aware that there are considerable discrepancies in health outcomes between Māori and Pakeha and between Māori and other ethnic groups. Māori have a greater incidence and mortality rate for diseases such as diabetes, cardiovascular disease and cancers; and a considerably shorter life expectancy.

Māori are the second largest ethnic group after Pakeha / Europeans and account for 15.5% of Aotearoa New Zealand's population. On the other hand, approximately 2.7% of New Zealand's active medical workforce are Māori; and the proportion of Māori practising surgery is even lower. The lack of a visible Māori presence and the very limited contribution of Māori in the delivery of surgical care may be one of the reasons that the workforce is not optimally responsive to, or understanding of, Māori healthcare needs and aspirations.

RACS, through our Māori Action Health Plan, is carrying out various initiatives to address Māori health inequity and improve Māori representation in the surgical workforce. We consider the two documents on which we are providing feedback underpin the work we are doing and we are very supportive of what they are aiming to achieve.

In regard to the revised *Statement on Cultural Competence and the Provision of Culturally Safe Care*, RACS believes the Medical Council's definition of cultural competence, as outlined in Paragraph 14 of the document, needs to be more specific. This is particularly important, given that RACS is considering introducing cultural competence as a 10th competency for achieving Fellowship. In order to teach cultural competence, we need to know exactly what it means and we need tools to assess it in order to measure doctors' competence.

RACS agrees with the Council's need to redefine cultural competence as it is increasingly at risk of becoming a concept that can mean many things to different people. RACS believes it would be very



helpful for the Medical Council to also include in this document a definition of, and some clarity around, the concept of cultural safety which originated in New Zealand in the 1980s as a way to redress Māori health inequities. Acknowledging the negative and ongoing impacts of colonisation on Indigenous peoples is a central component of cultural safety. To that end, RACS considers that this should be reflected in the statement's 'Cultural Competence Standards for Doctors' (Paragraph 15 of the document) by an additional item, 'understanding of the impacts of colonisation on health outcomes', to those listed under the heading 'Awareness and knowledge'.

In regard to the *Provision of Culturally Safe Care; and Achieving Best Health Outcomes for Māori – a Resource*, RACS believes that, in order for the principle of partnership – one of the core Treaty of Waitangi principles outlining the responsibilities of both government and Māori in the health sector – to be genuinely upheld, another item needs to be added to the ways in which doctors and their associated healthcare organisations can support Māori health equity. (Paragraph 24 of the document). We recommend this item be 'involving Māori at the beginning of policy / strategy development'. This would reflect the need for initiatives to achieve health equity to be developed *by* Māori, instead of *for* Māori.

Thank you again for the opportunity to give feedback and we look forward to being involved in the next steps.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Nicola Hill', written in a cursive style.

Dr Nicola Hill FRACS
Chair, New Zealand National Board



**The Royal Australian
and New Zealand
College of Obstetricians
and Gynaecologists**
Excellence in Women's Health

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10 July 2019

Medical Council of New Zealand
SConsultation@mcnz.org.nz

Tēnā koutou

Cultural Competence, Partnership and Health Equity Consultation on revised documents

Thank you for the opportunity to provide feedback on the Medical Council of New Zealand's draft documents '*Achieving Best Health Outcomes for Māori: a Resource*' and '*Statement on cultural competence and the provision of culturally-safe care*'.

Te Kāhui Oranga ō Nuku (formerly the New Zealand Committee) of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has endorsed a formal statement:

RANZCOG recognises the special status of Māori as tangata whenua in Aotearoa New Zealand and is committed to meeting its obligations as Te Tiriti o Waitangi partners.

RANZCOG supports and applauds the intent of the Medical Council New Zealand documents to provide clear guidance on the importance of Māori health, the crucial need for equity to be addressed, and the role that doctors can play.

RANZCOG's view is that it is important to support and foster doctors' interest in providing culturally competent and culturally safe care for their patients. We encourage an approach that builds clinicians' skill and confidence in providing such care, rather than approach which is confrontational or directive and risks alienating those beginning the journey of self-reflection on cultural safety.

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

RANZCOG generally supports the definition of cultural competence documented in Paragraph 14. We note that the final sentence in this section '*Council requires doctors to influence healthcare to reduce bias and promote equity*' seems to go beyond a definition of cultural competence to outlining Council's expectations of doctors. It seems to be a directive statement on expectations rather than a definition. We recommend that this statement be removed as the expectations of doctors is covered in the next section on standards for doctors.

RANZCOG generally supports the proposed cultural competence standards outlined for doctors in Paragraph 15. We make the following comments and suggestions:

Paragraph	Suggested change	Rationale
15.a.i.	That 'your cultural values' is amended to 'the cultural values you hold'.	'Your cultural values' implies they are static whereas 'the cultural values you hold' frames the values as something that can change over time, and with greater awareness and knowledge.
15.a.ii.	That the sentence becomes 'A commitment to the ongoing development of your cultural awareness and practices so that it becomes an integrated part of your work.'	Sets a clear aspiration of greater cultural awareness as a normal part of all doctors' work.

15.b.i.	That this be amended to 'An awareness of the limitations of knowledge and an openness to ongoing learning and development.' That a separate statement be 'A commitment to ongoing self-reflection on experiences working with patients.'	Partnership with clients on learning and development seems somewhat unclear. We wonder if there are two separate things - openness to ongoing learning and development and learning from self-reflection on experiences with patients?
15.b	That an additional statement is added 'Awareness of the potential gap between actual behaviours and self-reflection, and an openness to feedback from others.'	It is important that self-reflection does not confirm and further entrench biases.

RANZCOG acknowledges that the '*Statement on cultural competence and the provision of culturally-safe care*' places very clear and serious obligations on all doctors to ensure that they are taking specific and demonstrable steps to increase their cultural competence and ability to provide a culturally safe service. RANZCOG has introduced a mandatory component on cultural competence into the FRANZCOG Training Programme. In New Zealand this is an online and kanohi ki ke kanohi workshop course '*Application of the Hui Process/Meihana Model to Clinical Practice*', which is facilitated by MIHI - Maori Indigenous Health Institute, Otago University in Christchurch. RANZCOG also encourages all Fellows and SIMGs to complete the course. We believe that the requirements in the standards for doctors will place a greater onus on all Fellows to complete such training, and we support this.

Achieving Best Health Outcomes for Māori: a Resource

RANZCOG supports the rationales provided for addressing Māori health and health equity as documented.

RANZCOG supports the guidance provided in Paragraph 24 on how doctors and healthcare organisations can support Māori health equity.

Concluding comments

RANZCOG is committed to supporting its trainees and Fellows to develop their cultural competence, and in so doing play a role in addressing the health needs of Māori, and greater equity in the New Zealand health system.

We are happy for our submission to be published and identified as the submission from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

If you need further information on any of the above please contact us through Catherine Cooper, RANZCOG New Zealand Manager at ccooper@RANZCOG.org.nz.

Nāku iti noa, nā



Dr Celia Devenish
Chair Te Kāhui Oranga ō Nuku
(formerly the NZ Committee of RANZCOG)



Dr Leigh Duncan
Chair He Hone Wahine

NEW ZEALAND BRANCH

09 July 2019

Medical Council of New Zealand
PO Box 10509
The Terrace
Wellington 6143
New Zealand

via email to: SConsultation@mcnz.org.nz

Re Cultural Competence, Partnership and Health Equity – Consultation on Revised Documents

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) welcomes the opportunity to comment on the draft revised *Statement on cultural competence and the provision of culturally safe care* and *Achieving best health outcomes for Māori: a resource*.

RANZCO's mission is to drive improvements in eye health care in Australia, New Zealand and the Asia Pacific Region through continuing exceptional training, education, research and advocacy. Underpinning all of the College's work is a commitment to best patient outcomes, providing contemporary education, training and continuing professional development, evidence-based decision making, collaboration and collegiality.

We have reviewed the documents and agree with the new cultural competence documents and how they specifically apply to Māori and ophthalmology care in New Zealand. However, we also acknowledge that Pasifika, like Māori, suffer very poor health outcomes in New Zealand and would therefore seek to ensure that the Medical Council of New Zealand considers drafting similar documents to improve health equity and cultural competence amongst Pasifika in New Zealand.

Thank you for your consideration.



Dr Peter Hadden
NZ Branch Chair, RANZCO

CC: Maori and Pasifika Health Committee Chair: Dr Will Cunningham

New Zealand Branch

The Royal Australian and New Zealand College
of Ophthalmologists ACN 000 644 404
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8 July 2019

Ms Rayleen Bateman
Medical Council of New Zealand
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By email: sconsultation@mcnz.org.nz

Tēnā koe Raylene

Re: Cultural Competence, Partnership and Health Equity – Consultation on Revised Documents

Introduction

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide comment on the Medical Council of New Zealand's (MCNZ) revised discussion documents on *Cultural Competence, Partnership and Health Equity*.

The RANZCP's New Zealand National Committee – Tu Te Akaaka Roa, working with New Zealand-based faculties and Te Kaunihera, mo ngā kaupapa Hauora Hinegaro Māori, including Kāumatua Mr Wi Keelan and Ms Moe Milne, have reviewed the document and tautoko the work by the Medical Council of New Zealand (MCNZ) to:

- Support doctors to improve their cultural competence.
- Increase the emphasis on partnership and health equity to improve outcomes for Māori.

The RANZCP supports the work by the MCNZ to influence equity for Māori through improvements in cultural competency. It aligns with our work to achieve high quality mental health outcomes for Māori through promotion and advocacy of the right to culturally appropriate, accessible and effective psychiatric care. We do this by supporting the psychiatric mental health workforce in New Zealand to strengthen understanding and demonstrate cultural competence.

Assessment of cultural competence is integrated into the training of psychiatrists, including the understanding of the role of Te Tiriti o Waitangi. Awareness of its core principles of participation, partnership and protection within mental health services is encouraged through our Continuing Professional Development programme. Translating awareness through practical learning activities such as peer review and audit require demonstration through actions to change practice and improve practitioner competence (RANZCP 2019).

The RANZCP is committed to having trainees who are culturally competent and self-reflective as part of their training journey and assessment. Therefore our College advocates for all Colleges to have robust processes for trainees to both learn and participate in cultural competence practice as part of training and to be included in examinations. In the New

Zealand context, the NZMC statements on cultural competence could be embedded into training outcomes.

The RANZCP aligns its work on cultural competency with a range of professionals and organisations to produce resources that guide improvements in the practice of cultural competency. In addition, we work with communities of interest¹ to increase understanding, application and demonstration of cultural competence, partnership and health equity (RANZCP, 2000).

A. Draft 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 RANZCP considers the second bullet point would be strengthened by an aspirational refinement to reflect the intent, e.g. “The commitment by individual doctors to increase their awareness, acknowledge and address any biases, attitudes, assumptions, stereotypes and prejudices that *limit the ability to increase the quality of healthcare and achieve equity for patients*”.

We note that the fourth bullet point addresses MCNZ expectations in a positive and pragmatic way.

2. Paragraph 15 of the statement specifically outlines the cultural competence standards Council expects of doctors.

The RANZCP notes the move to increase individual responsibility for cultural competence by demonstrating actions, rather than a tick the box approach. We concur with the proposed changes outlined in paragraph 15, and support the use of active language in the revised version to improve clarity and expectations.

We recommend using existing methods to integrate cultural competence throughout practice rather than as an add-on. Our CPD programme includes professional development plans and activities which guide identification and reflection of chosen activities. These are proven to be effective for assessing effectiveness of care and improving aspects of practice, including cultural competency (RANZCP, 2018). We note that peer review through regular practice visits are also known to positively influence aspects of practice (Malatest, 2017).

Do you agree with the proposed standards? What changes (if any) do you suggest could improve these draft standards?

RANZCP Comment:

To reinforce practices that influence change we suggest the opening sentence on *Awareness and Knowledge* read, ‘Cultural competence requires you to *demonstrate* engagement in ongoing self-reflection and self-awareness.’

¹ Te Kaunihera has a number of community members to draw from a Te Ao Māori world view.

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.

The RANZCP notes that the systematic neglect of culture in health and health care is identified as the single biggest barrier to advancing equity in health, worldwide (Napier, 2014a). We fully support an increased focus on doctors examining the impact of their cultural understanding and practice to increase the impact of clinical interventions.

The high economic and social costs of failing to acknowledge biases can create knowledge gaps and interfere with effective working practice. Providing care in purely clinical terms leaves health systems ill-equipped to understand the psychological, social and cultural drivers of illness and health of disadvantaged populations (Napier, 2017b). We consider that better understanding of the interrelationships between culture and health will have a positive effect on equity and outcomes.

B. Draft Achieving best health outcomes for Māori: a resource

4. Paragraph 27 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?**

Awareness of cultural contexts is critical to health equity

Clarify expectations of cultural competence

The RANZCP supports the view that all doctors practising in New Zealand should understand the impact of their care for Māori and work towards improving their awareness and practice of cultural competency. While trusted sources of knowledge are useful, we consider increased exposure to practical learning opportunities would be more beneficial in improving equity. Undertaking activities which enable doctors to work in different settings connects them with different perspectives and approaches. In particular, cultural contexts, diverging value systems and health beliefs. Working within world views that are different to their own is known to improve the impact of care and reduce health inequities (Napier, 2017b).

Health professionals who are encouraged to be more focused on equity and quality processes play a greater role in influencing equitable outcomes

We consider improved outcomes for Māori will not be achieved by doctors working in isolation. Cultural competency approaches that increase participation in integrated models of clinical care are known to work. In particular, the creation of multidisciplinary teams that collaborate with community services, and include whānau, have improved practice and increased the commitment to addressing equity (Institute of Health Equity, 2018).

Engagement in CPD can strengthen the commitment to cultural competency and recognition

The RANZCP supports the need for doctors to understand how culture influences health outcomes and design solutions to effect inequities experienced by Māori (MCNZ, 2017A). The RANZCP², already supports its members and trainees to improve their knowledge,

² For example the RANZCP has two kaumātua available to guide our work in regards to cultural competency and a Māori Mental Health Committee - Te Kaunihera.

skills and practice of cultural competence through CPD programmes (RANZCP, 2019). The MCNZ may also consider how the practice of co-design could be integrated as an approach to improve cultural competency and whānau participation (HQSC, 2019).

Cultural competence activity as part of recertification

We uphold participation in recertification programmes as an effective mechanism for changing practice. We note that the Australian Medical Council has introduced five specific accreditation standards relating to cultural competence. While this expectation has reinforced the importance of cultural competence (MCNZ, 2017), there is no guarantee that practitioners will embed cultural competence within their practice to deliver changes in equity. We consider that College CPD programmes which include requirements for self-reflection and actions taken to improve practice are more likely to generate change and improvement.

A dilemma for cultural competency in multidisciplinary teams

There are some pitfalls in using quantitative data to understand effectiveness of cultural competency in a multidisciplinary team environment. In this space all practitioners contribute to a patient's care, and note that this may need further exploration when using external data sets to inform an individual doctors' practice (RANZCP, 2019). We suggest ongoing discussion with the Colleges on the design of CPD activities would be useful to understand the tensions and opportunities with relation to cultural competency.

5. Please provide any other feedback about the draft *Achieving Best Health Outcomes for Māori: a resource that you think Council should consider.*

RANZCP Comments:

The RANZCP takes equity seriously. To support our leadership role we need high level guidance on equity and cultural competence to set standards for best practice. We support members, trainees, supervisory and educational roles by embedding cultural competence through our CPD programme using the CanMEDS framework³.

We have a range of supporting materials to enable doctors to meet cultural competence requirements within their CPD activities. We acknowledge the MCNZ resources⁴ which provide a foundation for doctors to develop an understanding of Māori and Pacific people and recognise their specific health needs, but doctors also need to review their own attitudes. In this respect we call for the MCNZ to provide leadership on interpretation of the statements and provide opportunities for national deliberation to inform development of new learning frameworks and resources.

Resources/approaches:

- **Learnit⁵**

The RANZCP has developed a range of modules within the Learnit online platform that can address members' learning some at a basic level and also provide clinical presentations.

³ CanMEDS is a framework that identifies and describes the abilities physicians required to effectively meet the health care needs of the people they serve. These abilities are grouped thematically under seven roles. A competent physician seamlessly integrates the competencies of all seven CanMEDS Roles.

⁴ For example, "Best health outcomes for Māori: Practice implications"

⁵ The RANZCP's online learning platform for CPD activities. It includes a wide range of resources including online courses, podcasts, interactive learning modules, webinars, videos etc.

- **Choosing Wisely**

We note that Choosing Wisely New Zealand has partnered with Te ORA to undertake a research project to improve shared decision making between health professionals and Māori consumers and their whānau.

- **Takarangi Competency Framework⁶**

The RANZCP uses the Takarangi Competency Framework to inform evidence and practice of Māori responsiveness requirements. It identifies specific descriptions of practitioner competencies and focuses on demonstrated practice rather than just knowledge. The approach provides for the aspiration to excel in practice, utilise Māori values, beliefs and experiences with therapeutic intent, and contribute to positive outcomes.

- **Cultural Competence Assessments⁷**

A cultural assessment and report provides guidance to understand the effectiveness of cultural practice. The process of engaging in collective kōrero, seeking feedback from tāngata whaiora and whānau about what they consider important, enhances cultural understanding and guides practice. To determine best tikanga practice, an assessment would be undertaken before and after a meeting to ensure there has been informed agreement with tāngata whaiora, whānau and hapū. Where ever possible a recognised kāumatua with cultural expertise and lived experience, would be available to support safe cultural competency practice.

In conclusion

The RANZCP supports the move to reduce variation and improve equity by demonstrating proficiency in cultural competency. We also note that cultural competency must have a practical component and consider that practitioners must also challenge their own cultural competency, e.g. including addressing their own cultural bias. To assist our member psychiatrists to understand the impact of colonisation, we are currently developing a position statement on Care Informed by Trauma.

The ability to implement new approaches to cultural competency within clinically led service delivery is restricted due to a lack of ethnicity data. This hinders collective action to address equity. To enable change the Ministry of Health, District Health Boards and Health Quality

⁶ The Takarangi Competency Framework. The development of the framework, its structure and systems, has been a collaborative effort over several years by a group of individuals, including Wi Keelan and Moe Milne of the RANZCP Te Kanuihera Committee, and at times involved Ngā Manga Puriri, ADHB Māori Mental Health, NAC, Matua Raki and the Northern Region Māori Workforce Development Group. The Roopu Kaitiaki continues to safeguard and preserve the cultural and intellectual integrity of the taonga they shaped. Matua Raki. Available at: <https://www.matuaraki.org.nz/initiatives/takarangi-competency-framework/159>

⁷ Advice from a person with lived experience on RANZCP Te Kaunihera.

- Treat culturally safe care as a right not an add-on.
- Equity and safety are the main points for our people, this means they are somebody not a no-body.
- Learn to address Māori correctly.
- Enable whānau to participate in whakaaro planning and healing.
- Involve a kaumatua where possible.
- Learn how to set up a hui, and ask the whānau, where they would like to meet.
- Learn to follow cultural protocols and show respect. Ask a kaumatua or kuia for guidance on appropriate language and tone, e.g. e te kaumatua / e te kuia - what are your feelings thoughts?
- Discover, what do see, do you know why or how the experience affecting Tangata Whaiora.
- Work together to identify, where to go to move forward.

and Safety Commission have a key role in providing access to nation-wide clinical outcomes data, supporting workforce and growing the Māori workforce.

We note the key role of the MCNZ in guiding cultural competence and reinforcing the need for greater numbers in the Māori medical workforce. We support alignment with other organisations to support trainees with learning and development in cultural competency.

We strongly reinforce the importance of quality checked and interpreted national data⁸ and information about successful initiatives being fed back into the system to support learning and development of cultural competency. We caution that proceeding with implementation of the reviewed MCNZ documents without building in evaluation to understand the impact of change would also be a lost opportunity, and recommend seeking guidance from organisations that hold data and identify measures which can demonstrate success with cultural competency, participation and equity.

Overall, the RANZCP is supportive of the revised documents and consider that it moves the practice of cultural competency significantly forward. We look forward to viewing the final version and reinforce the need for continuing dialogue on cultural competency, partnership and health equity.

We look forward to continuing sector discussion the issues raised in consultation. The National Manager, New Zealand, Ms Rosemary Matthews who supports the New Zealand based Committees will be in contact with you shortly to arrange a meeting. In the meantime, if you require further information please contact Rosemary on 04 4727 265 or by email rosemary.matthews@ranzcp.org.

Ngā mihi nui



Dr Mark Lawrence, FRANZCP

Chair, New Zealand National Committee
Tu Te Akaaka Roa



Dr Claire Paterson, FRANZCP
Chair, Te Kaunihera

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The Royal Australian and New Zealand College of Radiologists®

10 July 2019

Medical Council of New Zealand
PO Box 10509
The Terrace
Wellington 6143
New Zealand

Re: Cultural Competence, Partnership and Health Equity - Consultation on Revised Documents

Thank you for the opportunity to provide feedback on the Medical Council of New Zealand's (MCNZ) statements, in partnership with Te Ohu Rata O Aotearoa (Te ORA), on *Cultural Competence and Best practices when providing care to Māori patients and their whānau*.

The Royal Australian and New Zealand College of Radiologists (RANZCR) is the peak body advancing patient care and quality standards in the clinical radiology and radiation oncology sectors. RANZCR represents over 4,500 members in New Zealand and Australia, including over 600 in New Zealand.

RANZCR's role is to drive the safe and appropriate use of radiology and radiation oncology to optimise health outcomes through leadership, education and advocacy.

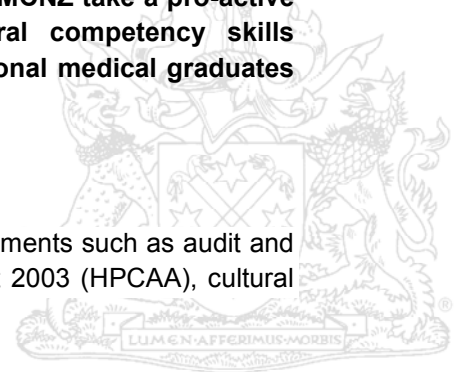
The proposed MCNZ statements provide standards for doctors to provide culturally safe care to patients and families/ whānau, and guidance for doctors to support the achievement of best health outcomes for Māori. RANZCR recognises the health workforce is diverse, and the health populations served are diverse, resulting in increased cross-cultural interactions between patients and clinicians. We support MCNZ's proposed statements and affirm the position that cultural competence means staff have the attitudes, skills and knowledge needed to achieve the statements' outcomes. We would like to provide specific feedback on the training aspect of how the outcomes are best delivered.

1. Training to deliver outcomes

The College recognises that acquiring cultural competence is a cumulative process occurring over many years and in many contexts, and that terms including 'cultural competence' and 'culturally safe care' will continue to evolve. Whilst definitions of these are useful, we would like to emphasise the importance of delivering outcomes in a meaningful and practical way. Certainly, it is difficult to prescribe the teaching of 'self-examination' and 'cultural safety', however resources such as text and videos, which remain one of the mainstays in cultural education, risk falling short of connecting cultural analysis to practical cultural competency. **We recommend that MCNZ take a pro-active role in fostering practical training and advice around cultural competency skills development, especially considering the large number of international medical graduates (IMGs) in the workforce.**

2. Continuing Professional Development (CPD)

RANZCR notes that whilst MCNZ mandates clinical competence requirements such as audit and peer review under the Health Practitioners Competence Assurance Act 2003 (HPCAA), cultural



competence is not specified in the same way. At the same time, we acknowledge the inherent challenges in developing objective measures for assessing cultural competence in practice and on patient outcomes. **We request clarification around whether there is likely to be any impact on existing continuing professional development requirements from the proposed statements.**

3. Translation of Māori terms

RANZCR highlights that for the purposes of comprehension it would be helpful for translations to be provided throughout each of the proposed statements where Māori terms *ie. tangata whenua* are used in the text.

RANZCR thanks the Medical Council of New Zealand for the opportunity to contribute to this consultation. Please contact our RANZCR office in New Zealand directly on +64 4 472 6471 or NZbranch@ranzcr.org.nz if you would like to discuss the feedback provided in this submission.

Yours Sincerely,

Dr Gabriel Lau

Chair, New Zealand Branch

Royal Australian and New Zealand College of Radiologists



20 June 2019

Ref: PT019-28

Ms Joan Simeon
Chief Executive
Medical Council of New Zealand
PO Box 10509
The Terrace
WELLINGTON 6132

via email: sconsultation@mcnz.org.nz

Tēnā koe e Joan,

Re: Cultural competence, partnership and health equity – consultation on revised documents

Thank you for the opportunity for the Royal New Zealand College of General Practitioners (the College) to provide feedback on these draft revised documents:

- *Statement on cultural competence and the provision of culturally safe care (Appendix 1); and*
- *Achieving best health outcomes for Māori: a resource (Appendix 2).*

We would like to acknowledge the work that Council and Te Ohu Rātā o Aotearoa (Te ORA) have done in revising and preparing these documents for consultation with doctors and stakeholders such as ourselves.

The College's Tumuaki Māori, Tengaruru Wi-Neera, has been actively involved in the development of these revised materials, and as such, the College fully supports the draft documents, particularly:

- the definition of cultural competence;
- cultural competence standards for doctors; and
- guidance for doctors and healthcare organisations to support achieving Māori health equity.

The College has also notified its members that the draft revised documents are available online and has invited them to send their comments directly to Council by the due date.

Nāku noa, nā

Peter Tynan
Interim Chief Executive

19 July 2019

Joan Simeon
Chief Executive Officer
Medical Council of New Zealand
PO Box 10509
The Terrace
Wellington 6143

Tēnā koe Joan

Re: CCDHB feedback to *Cultural Competence, Partnership and Health Equity – Consultation on Revised Documents*

Thank you for the opportunity to provide feedback on this important work the Medical Council of New Zealand is undertaking in partnership with Te Ohu Rata O Aotearoa.

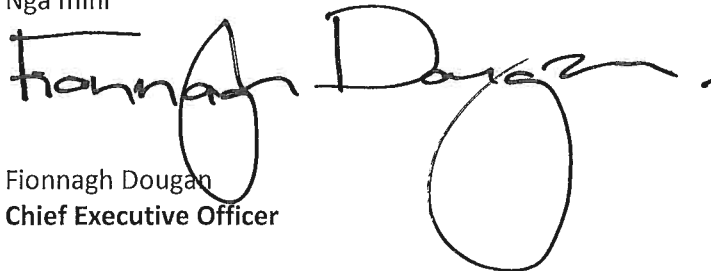
I am pleased to submit the Capital & Coast District Health Board (CCDHB) response to the draft revised documents for consultation including:

- *Statement on cultural competence and the provision of culturally-safe care*
- *Achieving best health outcomes for Māori: a resource.*

Our submission responds to the questions provided for each of the documents (see below) and has been discussed and agreed by the CCDHB Executive Leadership Team.

I agree to the CCDHB submission being published, and look forward to seeing the results of the consultation. The final documents will be invaluable in our work across the organisation to address health equity and improve Māori health outcomes.

Ngā mihi



Fionnagh Dougan
Chief Executive Officer

Cultural Competence, Partnership and Health Equity –

CCDHB feedback to Medical Council of New Zealand and Te Ohu Rata o Aotearoa

Draft 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?**

Yes, CCDHB agrees with the proposed definition of cultural competence.

CCDHB notes the increasing recognition of cultural safety and the distinction being made between the requirement for doctors **to be** 'culturally competent' and **to provide** culturally-safe care'. This is a useful distinction for our work as we further integrate cultural safety into the cultural competency training we provide.

CCDHB also agrees that the definition of cultural competence evolves over time. This is our experience having provided cultural competency courses for CCDHB staff for over ten years, as well as developed and taught an NZQA-recognised cultural competency programme – Te Tohu Whakawaiora (Certificate in Health Care Capability) for five years. As a result, we are mindful of our responsibility to stay well informed and abreast of evidence-based developments in this area.

- 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?**

Yes, CCDHB agrees with the proposed standards.

In regards to improving the draft standards, CCDHB suggests the following:

- We agree with the point that '...there are risks associated with focusing on the acquisition of knowledge about 'other cultures' such as inappropriate generalising and stereotyping.' We note that in our observation of staff attending our cultural competence courses, this can occur and needs careful management.
- We also note *bii* in the section '*Awareness and knowledge*' that clinicians are required to acknowledge '...that general cultural information may not apply to specific patients and that individual patients should not be stereotyped'.
- Our suggestion is that this needs strengthening, for example with an additional 'skill' included that addresses this 'acknowledgment', eg 'Recognise when you are generalising or stereotyping the patient's cultural differences or preferences.'

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

CCDHB notes that the health sector, including doctors, has been very slow in accepting that quality ethnicity data – including the collection, monitoring, analysis and reporting of both performance and workforce information – is a critical component of providing culturally safe care.

We suggest the Council should consider how ethnicity data can be incorporated into the draft statement.

Draft *Achieving best health outcomes for Māori: a resource*

- 4. Paragraph 27 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?**

CCDHB agrees with the key points included in Paragraph 24 (27?).

In regards to improving this guidance, CCDHB suggests the following:

- inclusion of a reference to the need for doctors and their associated healthcare organisations to demonstrate a commitment to supporting a strong Māori health workforce
- as in 3 above, that Council should consider how ethnicity data can be incorporated into this section.

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

CCDHB notes and supports Council's recognition of the special status of Māori as the tangata whenua of Aotearoa New Zealand and the clear rationale provided for addressing Māori health inequities supported by both needs-based and rights-based arguments.

Taurite Ora: CCDHB Māori Health Strategy and Action Plan 2019-2030, recently approved by the CCDHB Māori Partnership Board and CCDHB Board, aligns with this and is focused on health equity for Māori and improved Māori health outcomes.



RACP
Specialists. Together
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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 Zealand¹.

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 Aotearoa². 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 2016/17⁵.

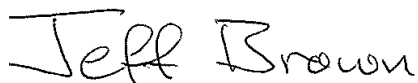
Paragraph 15 lists areas of inequity for physical health conditions experienced by Māori, including cardiovascular disease, stroke, rheumatic fever and lung cancer. In recognising the critical importance of frameworks and models of Māori health, such as Te Whare Tapa Whā, the RACP would amend this paragraph 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



Dr Jeff Brown
Aotearoa New Zealand President
The Royal Australasian College of Physicians

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.

#40

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Page 1: Statement on cultural competence and the provision of culturally-safe care

Q1 Do you agree with the proposed definition of cultural competence?(see paragraph 14 of the draft Statement on cultural competence and the provision of culturally-safe care)

Yes,

Do you have any suggestions on how the draft definition could be improved?:

The opening sentence of the draft Medical Council definition of cultural competence states that cultural competence is the requirement for doctors to examine the potential impact of their and their patients' culture on clinical interactions and healthcare service delivery. The Midwifery Council would suggest that competence in anything is not the requirement to do something, but rather the act of doing that which is required. A possible rewording to reflect that change in focus could be something like - cultural competence is doctors proactively examining and reflecting on the potential impact of their and their patients' culture on clinical interactions and healthcare service delivery.

Q2 Do you agree with the proposed standards outlined in paragraph 15 of the draft Statement on cultural competence and the provision of culturally-safe care?

Yes,

What changes (if any) do you suggest could improve these draft standards?:

The Midwifery Council would suggest that a stronger connection is made between the actions of the doctor and the experience of the patient. Repeating the same cultural competency actions are not a guarantee of culturally-safe experiences for different patients. The patient needs to be engaged with to ensure their particular experience is meeting their unique needs. Strengthening the communication skills section by having a more overt requirement to engage with the patient around their needs may be beneficial to enhancing the patient experience.

Q3 Do you have any other feedback about the draft Statement on cultural competence and the provision of culturally-safe care that you think Council should consider?

Yes:

In 2001 Mason Durie (Cultural Competence and Medical Practice in New Zealand) stated that cultural safety centers 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. Similarly, Jessica Bell wrote in 2009 (Cultural competence in health care of Aboriginal peoples) that cultural safety is an outcome of cultural competence. In the health setting it is the experience as perceived by the patient, based on the [cultural competence] actions of the health care provider. These comments support the Medical Council's general framing of cultural safety as relating to the cultural competence actions of the doctor. But more awareness of the patient experience in that context would be beneficial.

Page 2: Achieving best health outcomes for Māori: a resource

Q4 Paragraph 24 of the draft Achieving best health outcomes for Māori: a resource, 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?

Yes,

What changes (if any) do you suggest could improve this guidance?:

The Midwifery Council suggests the Medical Council considers an explicit comment that a key to achieving Māori health equality is to engage in ongoing discussions with Māori about why there are lower participation rates in health initiatives, or any other barriers as identified by Māori stakeholders and Māori patients. The Midwifery Council would also suggest the strengthening of links between health equity and a personal understanding of the clinician's own cultural perspective. Health equity and an understanding of what that means comes through delivering culturally safe care, and also through critical consciousness - i.e. being aware of one's own identity, the cultural lens which is how each person makes sense of and comes to an understanding of what surrounds them.

Q5 Do you have any other feedback about the draft Achieving best health outcomes for Māori: a resource that you think Council should consider?

Yes:

The Midwifery Council generally supports the position of the Medical Council in supporting Māori health equity as outlined.

Page 3: Submission Information

Q6 Your information

Name	Leon Mitchell
Organisation	Midwifery Council
Email address	leon@midwiferycouncil.health.nz

Q7 Your role/title

Policy and Risk

Q8 This submission is on behalf of:

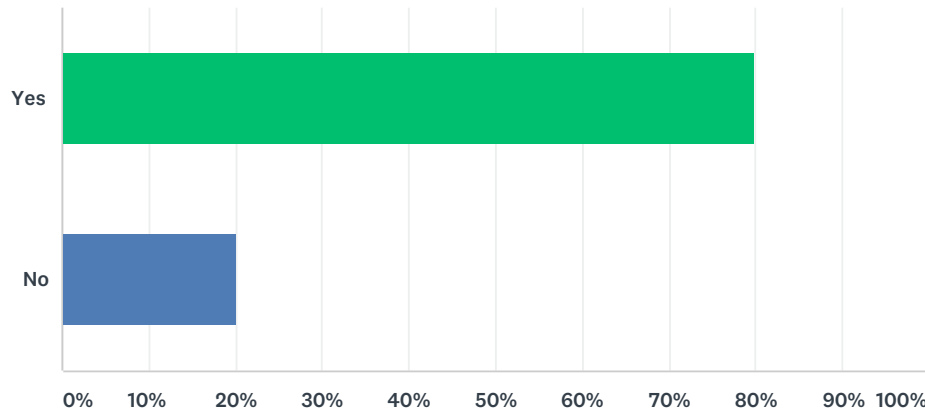
An organisation

Q9 I wish for my submission:

To be published as identified

Q1 Do you agree with the proposed definition of cultural competence? (see paragraph 14 of the draft Statement on cultural competence and the provision of culturally-safe care)

Answered: 40 Skipped: 0



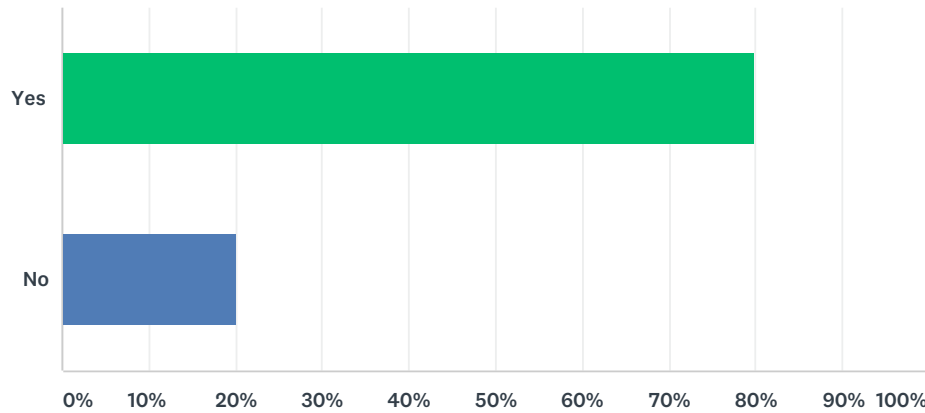
ANSWER CHOICES	RESPONSES
Yes	80.00% 32
No	20.00% 8
TOTAL	40

#	DO YOU HAVE ANY SUGGESTIONS ON HOW THE DRAFT DEFINITION COULD BE IMPROVED?	DATE
1	The opening sentence of the draft Medical Council definition of cultural competence states that cultural competence is the requirement for doctors to examine the potential impact of their and their patients' culture on clinical interactions and healthcare service delivery. The Midwifery Council would suggest that competence in anything is not the requirement to do something, but rather the act of doing that which is required. A possible rewording to reflect that change in focus could be something like - cultural competence is doctors proactively examining and reflecting on the potential impact of their and their patients' culture on clinical interactions and healthcare service delivery.	7/25/2019 9:44 PM
2	But I think needs more emphasis on improving equity of healthcare outcomes	7/13/2019 4:03 AM
3	I agree with Prof Curtis that we should be focusing on cultural safety instead of cultural competence. This is imperative in changing the culture of our society towards a less racially biased structure. However in achieving this, I believe emphasising cultural competence and mandating a basic knowledge of Te Ao Maori among all health practitioners is an important step	7/13/2019 3:44 AM
4	Many internationally trained doctors need to reflect bicultural rather than multicultural competence in an Aotearoa New Zealand setting. The Council cultural competence definition needs to clarify this by including: reference to Aotearoa New Zealand's bi cultural history and setting where health care services are delivered, service delivery needs to reflect both the patients and their whanau , who are currently not being included. opening statement should reflect doctors attitude to patients and their whanau which is under attitudes section but not included in definition.	7/10/2019 5:01 AM
5	"to influence healthcare to reduce bias" - this sometimes leads to conflict and doctors' leadership can be easily ignored, as most health organisations have very low numbers of Maori clinicians with a genuine interest in ensuring cultural competence of other professions in the health sector. The Council's statement should acknowledge systemic problems and the limits to doctors' power to exert their influence with regards to the clinical practice of allied professionals. This could serve as an encouragement or as a call for systems to take cultural competence more seriously and support doctors in their role of supporting culturally safe practice.	7/7/2019 3:11 AM

6	Yes and no! I think the points listed under 13 and 14 are important - but there is still a tension between continuing to try and redefine cultural competence, versus switching to use the very NZ specific and robust term of cultural safety. What I see in this definition is several of the aspects of cultural safety trying to be squashed into a different term. Can we change this document to a 'Statement on Cultural Safety', and then define cultural safety and cultural safety standards for Doctors?	7/6/2019 1:18 AM
7	The only point i would make is that it is important to acknowledge the potential benefits as well as risks of the interaction of two people from different cultural backgrounds. This is particularly so with differing cultural attitudes to domestic violence. The trick is to view the issues through the 1st person perspective of Maori, at the same time as bringing the benefits of a different cultural perspective into the interaction. The difficulty to overcome is how to do this without assuming or passing on a value judgement	6/22/2019 10:41 PM
8	This is well articulated and hard to improve on. I have experiences with medical students, who (with best intentions) seem to target smoking habit, obesity and non-compliance, without taking into account the history / impact of colonisation on a people. It may be absorbed in the third bullet point. I wonder, if we should add something along the lines, that patients had different journeys partially determined by (colonial) historic events to reach the current health status. Part of building a therapeutic relationship may be to acknowledge this journey.	6/11/2019 10:35 PM
9	Acknowledge the systemic racism that influences cultural bias.	6/10/2019 11:48 PM
10	I think that it is vital for council to recognise the MULTI-cultural nature of NZ whilst bearing in mind the effects of colonisation on the socio-demographic deprivation of Maori. This is a good general statement.	6/6/2019 9:40 AM
11	No. The responsibility to provide culturally safe care is good. What culturally safe care is really defined in paragraph 15 and so I read that as part of the definition.	6/4/2019 7:27 AM
12	Cultural competence should include all citizens of NZ. This include the Chinese whose population almost matches the no of Maoris and the Muslims who were attacked recently	6/1/2019 8:57 PM
13	I want to commend the MCNZ on the leadership it has taken in this field. The original statement is one that I frequent refer to in my teaching and wider lecturing around cultural competence. I welcome this opportunity to be involved in the up dating of the document	5/31/2019 11:49 PM
14	The fact that, as doctors we take a Hippocratic Oath on qualifying, should over-ride all other considerations as it encompasses what we, as doctors, went into the profession for. We treat all of our patients equally, irrespective of race, creed or colour, whether free or incarcerated. Surely this is what defines us. If we are being asked to treat patients differently based upon "race" or skin colour, surely that breeches our underpinning beliefs & principles? In addition, how do we define Maori? I do not now, nor will I ever, base my treatment on "race", ability to pay, or any other arbitrary yardstick, for to do so would make me an unworthy doctor & a hippocrite	5/31/2019 9:19 PM
15	On paper one can write anything they want. It does not matter so much but constant dialogue needs to be held with Maori and other disadvantaged patients. There needs to be beyond physical care, mental care to housing, diet and spiritual care	5/30/2019 3:12 AM
16	The commitment by individual doctors to acknowledge and address any biases, attitudes, assumptions, stereotypes and prejudices that may be influencing the quality of healthcare for some patients. (biases, attitudes, assumptions, etc - may not necessarily contribute to lower quality of care but a different approach, which sometimes might even be better/higher quality, more thorough).	5/30/2019 12:59 AM
17	thank god I am retiring soon - you are just hurrying up my decision	5/30/2019 12:18 AM
18	Treating people as you would want to be treated	5/30/2019 12:06 AM

Q2 Do you agree with the proposed standards outlined in paragraph 15 of the draft Statement on cultural competence and the provision of culturally-safe care?

Answered: 40 Skipped: 0



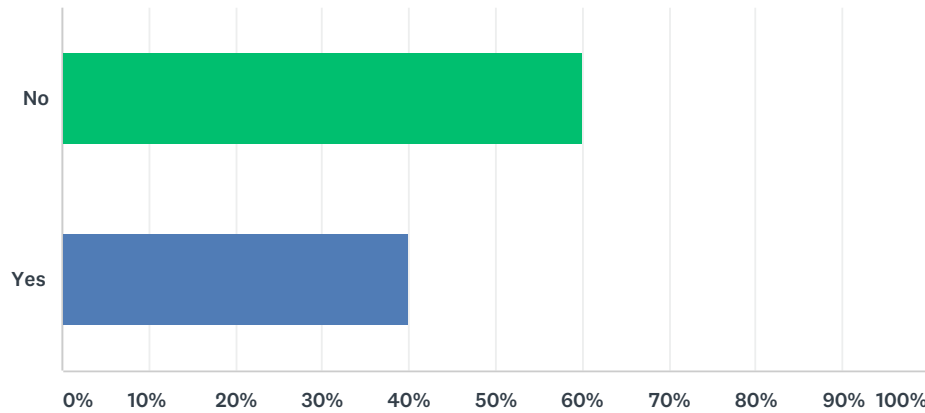
ANSWER CHOICES	RESPONSES	
Yes	80.00%	32
No	20.00%	8
TOTAL		40

#	WHAT CHANGES (IF ANY) DO YOU SUGGEST COULD IMPROVE THESE DRAFT STANDARDS?	DATE
1	The Midwifery Council would suggest that a stronger connection is made between the actions of the doctor and the experience of the patient. Repeating the same cultural competency actions are not a guarantee of culturally-safe experiences for different patients. The patient needs to be engaged with to ensure their particular experience is meeting their unique needs. Strengthening the communication skills section by having a more overt requirement to engage with the patient around their needs may be beneficial to enhancing the patient experience.	7/25/2019 9:44 PM
2	But I think again needs more emphasis on advancing equitable healthcare outcomes	7/13/2019 4:03 AM
3	In general: A stronger commitment to the articles of te Tiriti o Waitangi and Multiculturalism is required (see Waitangi Tribunal Kaupapa Maori inquiry recommendations for health sector change); Consistency in language - whanau are not always included with the patient in the bullet points; Under attitudes: Stronger wording is required (than "a commitment") to ensure attitude and practice change; Under skills: Demonstrating cultural competency through use of Te Reo Maori is missing from skills lists.	7/10/2019 5:01 AM
4	15.a.iv : ...to challenge the cultural bias and stereotypes of individual colleges, clinical teams or systemic bias... 15.c.ii : ...on the doctor-patient relationship and the management plan	7/7/2019 3:11 AM

5	I reiterate my point in question 1. Although there is a lot of good content about self-reflection, identifying doctor stereotyping and bias etc - there is still too much focus on understanding the "other". It is also lacking the requirement for the doctor to think about history and society as a whole and how that shapes discourse and systems that favour the dominant culture. More specifically I would suggest amending (b)(v) to: " An understanding that patients' AND DOCTORS' cultural beliefs, values and practices influence their perceptions of health, illness and disease; how they respond to and manage health and disease; and their interactions with others and the health care system". In (c) (ii) "Elicit cultural factors important to the DOCTOR AND PATIENT which might impact on the doctor-patient relationship. Also under (b) or (c) I think there needs to be added: • An understanding of how New Zealand's social and cultural history has shaped differential access to the determinants of good health for different groups, and therefore inequitable health outcomes • An understanding of racism, dominant-culture privilege, and power imbalances in systems and between individuals – and acting to eliminate these	7/6/2019 1:18 AM
6	Whilst I applaud the move beyond aspirational statements to a concrete focus upon attitudes, knowledge and skills, section c is still weak. I encourage you to look again at the wording in the skills section (as this is what will be tested in the case of future complaints or competence investigations). In particular, of c.iv and c.v could be combined into one stronger statement (or two), by rewording c.iv as "work with the patient's cultural beliefs, values and practices to understand the patient's experience of illness, reach a diagnosis and formulate a treatment plan". This is a non-trivial point: diagnosis itself is not a culture-free activity	6/13/2019 3:34 AM
7	Particularly I like the commitment not to impose your own cultural values and practices on the patient. (And - not to self - to still work toward offering best evidence therapy to this patient).	6/11/2019 10:35 PM
8	To be honest, this is basically good clinical care in any context.	6/6/2019 9:40 AM
9	Nil I read these as a definition of culturally safe care I really like this	6/4/2019 7:27 AM
10	The document as a whole is significantly deficient in addressing the issues of people who do not speak the language of their clinician. In discussing the legislative framework it needs to include the HDC Code Right 5(1) the right to effective communication. This right itself is in my view deficient in that it says "Where necessary and reasonably practicable, this includes the right to a competent interpreter." The qualification of "necessary and reasonably practicable" should be removed...it is included within clause 3 of the code for all the rights under the code by including in addition in this right it devalues the importance of working with an interpreter. It also refers to a "competent" interpreter. By definition I am unable to assess the competence of an interpreter. This needs to be a right to a professional interpreter. Clause C(Skills) (viii) is inadequate. I would refer you to my chapter in Coles. Clinicians need the skill when working with patients who have limited English proficiency (LEP) to assess whether the language assistance that they are using is adequate for the consultation that they are performing. We know that the availability of interpreters in New Zealand is inadequate (Language Line is only available business hours and Saturday morning) and that it is very common that clinicians see LEP patients frequently without trained interpreters. Without an interpreter many of the other rights under the HDC code are unavailable...in particular informed consent is impossible. I would recommend a whole new clause addressing the care of LEP patients based around the Coles Chapter on Working with Interpreters I would argue that this situation is a "systemic bias within health care services where this will have a negative impact on patients"	5/31/2019 11:49 PM
11	Please see answer above as I believe that as doctors we should treat everyone the same & thus the need to define this becomes irrelevant. This is not a racist viewpoint - far from it, it means that Celts, Chinese, Maori, Africans, etc, etc are all welcome to come to be seen by me assuming that they take on board the concept of self responsibility (assuming age & mental state allow it) & will do their best to minimise risks following intervention or follow treatment guidelines. I would NEVER change my options or plans based upon "race"	5/31/2019 9:19 PM
12	Section B - Awareness and knowledge: Proposed addition: An awareness that health care institutions and systems may be inherently biased and contribute to poor health outcomes for patients of different cultures.	5/30/2019 11:13 AM
13	It is difficult to ghetto into the shoes of patients in a 15 min appointment when every one , every day is brainwashed to believe that we can provide best care in a hurried 15 mins appointment we're dealing with physical ailment may be possible but other paradigm not touched	5/30/2019 3:12 AM
14	drop 15 c (skills) iv : this confusing, intimidating, wishy-washy	5/30/2019 12:04 AM

Q3 Do you have any other feedback about the draft Statement on cultural competence and the provision of culturally-safe care that you think Council should consider?

Answered: 40 Skipped: 0



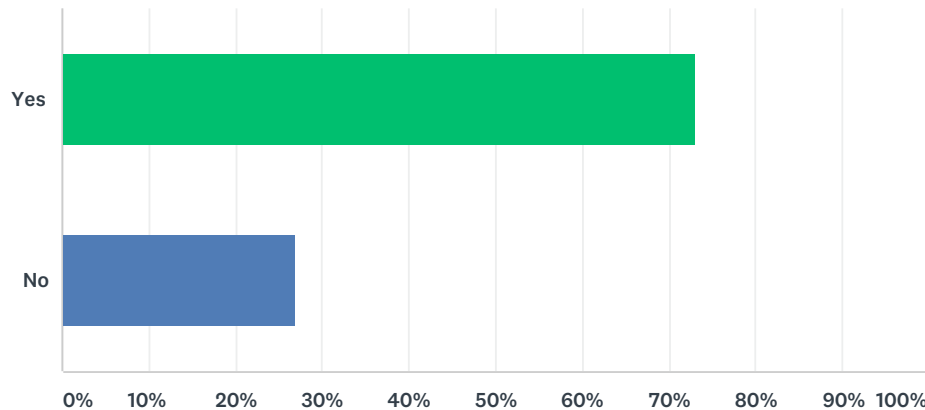
ANSWER CHOICES	RESPONSES
No	60.00% 24
Yes	40.00% 16
TOTAL	40

#	YES	DATE
1	In 2001 Mason Durie (Cultural Competence and Medical Practice in New Zealand) stated that cultural safety centers 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. Similarly, Jessica Bell wrote in 2009 (Cultural competence in health care of Aboriginal peoples) that cultural safety is an outcome of cultural competence. In the health setting is It is the experience as perceived by the patient, based on the [cultural competence] actions of the health care provider. These comments support the Medical Council's general framing of cultural safety as relating to the cultural competence actions of the doctor. But more awareness of the patient experience in that context would be beneficial.	7/25/2019 9:44 PM
2	Just to reiterate I think the end game of CC is equitable health care outcomes and so this should be emphasised in the statement	7/13/2019 4:03 AM
3	I think this is a good start but the ideas and resources to support practitioners /organisations needs to be more practical. Achieving equity is a goal we all have but the pathway to that is far from clear. Certainly self-reflection and identification of any personal or institution bias is important. However navigating existing community health services, connections with social services and other ways of improving the social determinants of health are major factors. Many health practitioners will not be aware of these existing resources and how to maximize this for their patients. Existing funding models of hospital and PHO silos are confusing for both patients and practitioners. Therefore we are not maximizing the health spend or the human resources for the people who require it the most. Whilst the role of this document is not to prescribe the operation of diverse DHBs and community organizations, I think that a statement that outlines where practitioners and organizations can begin to work better together would be amazing.	7/10/2019 8:45 PM
4	Language needs to be clear with the use of plain English. We agree with the use of the MOH health equity definition, for consistency across the health workforce.	7/10/2019 5:01 AM

5	The document refers to the cultural safety of the patient and quite rightly the attributes and attitudes of the doctors own culture. The problem for closing the gap is the age old difficulty of being unaware of the cultural requirements of the patient. They themselves may have attitudes which are not part of their culture, and attitudes which use their culture in a way not considered mainstream. Dialogue between patient and carer is therefore the only way to explore this for each individual. This may be time-consuming or may be simply stated by asking if the patient is happy with the proposed conduct of care.	6/14/2019 9:13 PM
6	No, it reads well. I am talking as a teacher working with our local MIHI team. We are straddling the tension between being culturally sensitive and as save as possible and still ensuring that (Maori) patients receive best care according to guidelines and evidence. Our research shows, they are still fighting for 'statins and stents'; something long achieved by most of the non-Maori (non Pacific) patients.	6/11/2019 10:35 PM
7	I am an Otago graduate 15 years ago. I do wonder about overseas trained specialists who come to NZ and how we can best help them to understand Maori culture?	6/4/2019 7:27 AM
8	I think the document should include a statement that patients should also demonstrate respect for the professionalism & expertise of the doctor & acknowledge that when patients are disrespectful, abusive or threatening that this undermines the relationship. Although not all patients & doctors can have satisfactory rapport conducive to a good therapeutic relationship, patients should also reflect on & acknowledge their cultural stereotypes & prejudices. It is not appropriate that doctors endure disparagement, harassment & violence on purely cultural grounds & that this is accepted as a routine part of patient care.	6/3/2019 1:16 AM
9	For all races	6/1/2019 8:57 PM
10	I note that the people listed as having developed this draft are predominantly Māori and from reading the names there appears to be no one from any other ethnic minority. I think this may explain why the important issue of interpreters has been missed as it is rarely an issue for Māori. I note that the same criticism could be made of the RNZCGP document on cultural competence and the Ministry of Health on line training module on cultural competence, both of which were also developed by Māori advisers. I fully support the focus that MCNZ has given to improving care for Māori but believe that this should not preclude addressing important issues that affect other ethnic groups. I would recommend that you seek input from other groups who have poor health outcomes for their input; Pacific, Asian, Refugee, Transgender for example.	5/31/2019 11:49 PM
11	Please see above. I believe that the documents are well intentioned but are culturally divisive & divide a Nation along "race based" lines with no clear indication what actually constitutes any particular "race". We need robust definitions if we are to offer different treatment algorithms dependent upon what the genetics of our patients are. I, frankly, find this appalling & racist. I understand that there is a need to improve the general well being of certain aspects of New Zealand's population, but quality improvement will not be improved by offering different standards of care to one aspect of the population over another. We should all be treated the same. We all bleed the same coloured blood. I am not happy about being expected to treat my patients differently, although I understand that religious & cultural differences need to be respected, I am not going to prioritise or offer different treatments based on cultural grounds	5/31/2019 9:19 PM
12	I feel that there will be more take-up of these competencies if there is an element built into CME. For example (for physicians), there could be a section in the RACP annual CPD/CME reporting regarding educational activities related to cultural competence. Initially this could be voluntary, but once there are a good number of regular educational activities/online modules available, this could become a mandatory requirement that had to be refreshed every 5 years.	5/30/2019 9:46 PM
13	This exercise is only relevant to those doctors caring for Maori patients and their families. It is obvious that Maori patients and their families should be treated the same as any other patient, regardless of ethnicity. Some specialists and other doctors have no use for this sort of politically correct indoctrination, particularly if it enforced as part of certification.	5/30/2019 7:08 AM
14	Read the WHO definition of health	5/30/2019 3:12 AM
15	It would be helpful if BPAC could provide online programs to enable doctors to achieve their CME cultural competence requirements.	5/30/2019 1:39 AM
16	we are a country of diverse cultures and apartheid where some are more equals should not be promoted	5/30/2019 12:18 AM

Q4 Paragraph 24 of the draft Achieving best health outcomes for Māori: a resource, 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?

Answered: 37 Skipped: 3



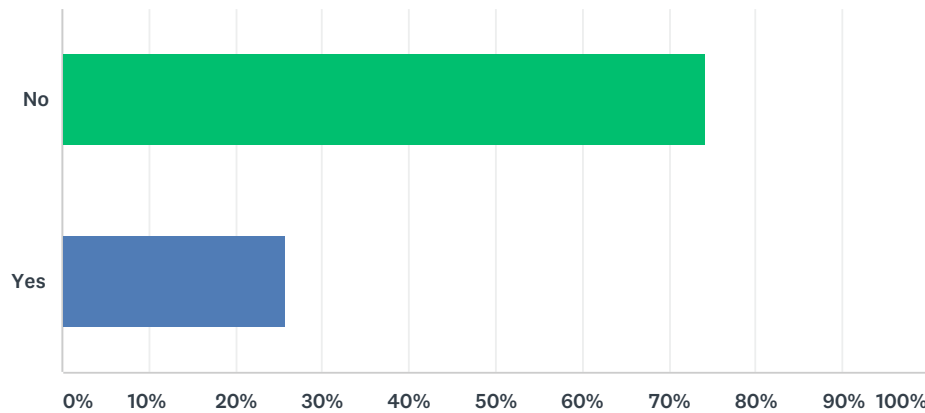
ANSWER CHOICES	RESPONSES	
Yes	72.97%	27
No	27.03%	10
TOTAL		37

#	WHAT CHANGES (IF ANY) DO YOU SUGGEST COULD IMPROVE THIS GUIDANCE?	DATE
1	The Midwifery Council suggests the Medical Council considers an explicit comment that a key to achieving Māori health equality is to engage in ongoing discussions with Māori about why there are lower participation rates in health initiatives, or any other barriers as identified by Māori stakeholders and Māori patients. The Midwifery Council would also suggest the strengthening of links between health equity and a personal understanding of the clinician's own cultural perspective. Health equity and an understanding of what that means comes through delivering culturally safe care, and also through critical consciousness - i.e. being aware of one's own identity, the cultural lens which is how each person makes sense of and comes to an understanding of what surrounds them.	7/25/2019 9:45 PM
2	See above more detail around navigation of existing health services and social services. organisations need to take more responsibility for the connectivity across providers. Otherwise utilisation of appropriate resources is not achieved.	7/10/2019 8:49 PM
3	Consistency of language use of Maori or indigenous in document. Needs to reflect and use te Tiriti o Waitangi articles rather Treaty based, that gives a different context to Maori and Tangata whenua. What cultural competency training does the MCNZ offer members?	7/10/2019 5:15 AM
4	More emphasis on Protection and how doctors could access training resources that will help them develop a better awareness of their duty to protect Maori patients in the spirit of the Treaty's principles.	7/7/2019 3:17 AM

5	In this document I think there is a particular need to highlight how New Zealand history, and colonisation have shaped differential access to the determinants of health for Māori, and therefore inequitable health outcomes. Irihapeti Ramsden (cultural safety pioneer) highlighted that developing cultural safety involves a critical analysis of existing social, political and cultural structures, and with respect to Māori, an understanding of NZ history, the colonial process, and racism - so that practitioners could put patients' health in a wider context rather than 'victim-blaming'. e.g. at point 25. Doctors and their associated healthcare organisations can support Māori health equity by: -understanding how the process of colonisation has shaped differential access to the determinants of health for Māori, and therefore inequitable health outcomes. Also under point 25. I would add that health organisations need to: o Have Māori health equity goals, policies, strategies and plans o Set and monitor Māori health equity targets (i.e. build in accountability to the goals and plans) o Build relationships and work collaboratively with Māori to make sure the organisation is effective at meeting the needs and aspirations of Māori o Promote use of equity focused quality improvement tools (e.g. audit, quality ethnicity data collection) and promote and share evidence-based pro-equity actions and initiatives o Invest in pro-equity initiatives, disinvest from those that impact negatively on Māori health equity	7/6/2019 1:50 AM
6	There needs to be awareness within the profession of the differences within Maoridom at the individual level in terms of beliefs and behaviour highlighted by the fact that many disenfranchised Maori are not engaged with local conventional iwi based governance structures, more so when they are manuhiri or lack the whakapapa knowledge or are disengaged because of whanaungatanga difficulties. Special tactics for providing healthcare for such Maori are needed that consider these matters.	6/12/2019 7:45 AM
7	As 51% of us doctors are overseas trained, maybe we can / should start with something like: - Doctors should familiarize themselves with the national, regional, local guidelines, policies and procedures designed to empower Maori. That is based on discussions with colleagues new in the country, who wish to 'cure' Maori and at the same time, do not know their local policies, which are often hard fought for.	6/11/2019 10:41 PM
8	I strongly believe that achieving best health outcomes for Maori entails ALL sectors working together rather than having silos of "Maori health providers" potentially providing duplicate care, or at worst poorer care. There needs to be improved communication such that we all use our skills to improve those in greatest need whether the person/family is Maori or otherwise, and whether the care provider is Maori or otherwise. Separating things in this way continues to undermine true cultural competence by forming a potentially two stream, and at worse 2 tier, health system.	6/6/2019 9:44 AM
9	Regarding point C - I do wonder if in addition to "local solutions" there could be some guidance here from some national expert group - there may well be some common themes of structures and processes that limit Maori health development. Perhaps also some examples of success stories already achieved to this end eg a community addressing a need. Perhaps this could be a separate document? Or perhaps even this point could just be elaborated on? eg a couple more sentences to help organisations with this process which sounds very worthwhile	6/4/2019 7:46 AM
10	Suggested addition: Recognise that self-determination is a key factor for Maori health and facilitate Maori determining their own health care priorities, delivery and services.	5/30/2019 11:20 AM
11	Only Maori people can say what is missing . Here listening skills are important	5/30/2019 3:15 AM
12	it is paragraph 24 In addition there should be resources for medical staff to engage/participate in cultural experiences and education, eg offer Te Reo language classes, marae visits or other appropriate cultural events.	5/30/2019 1:03 AM

Q5 Do you have any other feedback about the draft Achieving best health outcomes for Māori: a resource that you think Council should consider?

Answered: 35 Skipped: 5



ANSWER CHOICES	RESPONSES
No	74.29% 26
Yes	25.71% 9
TOTAL	35

#	YES	DATE
1	The Midwifery Council generally supports the position of the Medical Council in supporting Māori health equity as outlined.	7/25/2019 9:45 PM
2	Consider having compulsory Treaty of Waitangi training and understanding of Whaanau Ora Frameworks as part of ongoing workforce development.	7/13/2019 3:52 AM
3	Section 19 needs to be updated to reflect te Tiriti o Waitangi articles - Kawanatanga, Tino rangatiratanga, and Oritetanga. as the Treaty principles are outdated and no longer used.	7/10/2019 5:15 AM
4	Colleges must enrich their cultural competence training programmes and ensure that these evolve over time by systematically reviewing them. This might be relevant both to paragraph 20 and 24.	7/7/2019 3:17 AM
5	I should have put this feedback in the previous form about the 'Statement on cultural competence and the provision of culturally-safe care' - but here it is anyway.... We need to think carefully about how we assess and measure cultural safety. The shift back towards the concepts of cultural safety brings a need for more objective/outside feedback - handing over the power to others to give objective feedback on how safe and effective one is. More objective measures may include audit of practice, multi-source feedback, and client/community feedback – all of which could be used at both the individual and the organisational level. Since cultural competence/safety is not static, but a lifelong developmental and reflective process, assessment and measurement should not one-off, but should be undertaken on a regular ongoing basis using a range of tools.	7/6/2019 1:50 AM
6	see above :)	6/11/2019 10:41 PM
7	Tautoko the amount of systemic acknowledgement there has been in this review	6/10/2019 11:49 PM
8	NZMA can do whatever it wants in this regard, except to enforce its application as part of medical certification.	5/30/2019 7:09 AM
9	I think the provision of uptodate health statistics to illuminate the difference in Maori health risks and outcomes is good and could be expanded in to more than diabetes and CVD risk- specifically some paediatric statistics would be useful	5/30/2019 12:06 AM

<p>1 Cultural competence in Auckland is recognising the broad spectrum of multi ethnicity. Biggest challenge is linguistics. We have 48% asians and while middle class tangatawhenua enjoy the diversity lower deciles are replete with inter ethnic racism.</p> <p>We are here to make our clients healthy and to understand their perception of health, a d to educate. The Treaty and the Maori Wars are for historians primarily. Asian cultural multiplicity is by far our biggest challenge and is where our skills should be concentrated.</p> <p>Auckland is not Wellington.</p> <p>The future of 5 minute NHS style consulting is the future of cheap primary care.</p> <p>A simple anathema.</p>
<p>2 Hi there</p> <p>I'm a pgy4 ED training registrar and a NZ postgraduate medical entrant.</p> <p>My major concern with regard to cultural incompetence is that nearly 50% of our work force of junior RMOs in SDHB are foreign recruited. Many of the don't know anything about Maori culture at all. Or even that it exists.</p> <p>It defies the treaty to let these people treat our populace in my opinion. With no effort to train or upskill them with any cultural knowledge.</p> <p>It also undermines the skills and education received in Aotearoa medical training with regard to cultural competence.</p> <p>Happy to discuss further.</p> <p>Kia ora</p>
<p>3 I had a few minutes to read these documents today and feel I have to respond</p> <p>Although the content is mostly fine, parts of the statement are very badly written (the resource document less so)</p> <p>In both documents the section on Health Equity is particularly bad and mangles the MOH definition of Health Equity to give a completely different message</p> <p>Some people may indeed 'have differences in health status that are not only avoidable but unfair and unjust' (the MOH wording) but that is not the same as just saying 'differences in health status are unfair and unjust' (the wording in both draft documents).</p> <p>Having a serious illness or disability often seems very unfair – but that doesn't necessarily make it unjust, or indeed due to differential access to the resources to lead healthy lives.</p> <p>Sorry to be pedantic but these documents are important</p>
<p>4 The documents give no recognition of the large amount of effort most doctors put in to working across cultures to obtain good health outcomes. Just one aspect of this is that when patients require an interpreter, this doubles the consultation time.</p> <p>There is no recognition in the documents that medical practitioners are routinely working with considerable time constraints. In consideration of this, the standards and requirements should be regarded as aspirational, rather than all of these having to be achieved in each consultation.</p> <p>The documents appear to be silent on the greatest factor which results in good cross-cultural care: that the practitioner shows genuine interest in the patient and cares about achieving the best health outcomes possible.</p>
<p>5 Could/should all IMGs partake in a Maori cultural competency course as part of MCNZ processes? Something not dissimilar to the Otago University / RANZCOG Mihi Course?</p> <p>Thank you for considering this</p>
<p>6 Peer Group Observations on the NZMC statements 17 June 2019</p> <p>Observations made included:</p> <p>The documents give no recognition of the large amount of effort most doctors put in to working across cultures to obtain good health outcomes. Just one aspect of this is that when patients require an interpreter, this doubles the consultation time.</p> <p>There is no recognition in the documents that medical practitioners are routinely working with considerable time constraints. In consideration of this, the standards and requirements should be regarded as aspirational, rather than all of these having to be achieved in each consultation.</p> <p>The documents appear to be silent on the greatest factor which results in good cross-cultural care: that the practitioner shows genuine interest in the patient and cares about achieving the best health outcomes possible.</p>