

Principles of culturally competent care for Pacific peoples



The differences between New Zealand-born and migrant Pacific peoples

There are many differences between New Zealand-born and migrant Pacific peoples.

The traditional outlook, which includes an unquestioning demand for respect and process, doesn't always fit comfortably for a younger, New Zealand-born generation. Younger generations must often try to balance the demands of a conservative (or more traditionally-based) Pacific society with their own view of the world, which is increasingly gathered from overseas education and experience.

These differences can create division within the Pacific. A key example is around language; those who can speak the native language of the community may judge those who cannot, as lacking. Monolingual Pacific peoples may feel 'incomplete' and dislocated from family or social interactions.

Pacific-born Pacific peoples commonly:⁶²

- have a strong sense of 'who they are' and 'where they come from'
- are deeply connected to their birth village
- are less concerned about the opinions of those outside their 'group'
- prioritise family and social responsibilities over physical health

- view New Zealand as a source of income for meeting family and cultural responsibilities.

New Zealand-born Pacific peoples commonly:⁶²

- care about 'who they are' and 'where they come from'
- give less priority to cultural and church responsibilities
- experience conflict with family members when community responsibilities clash with their own needs
- are conditioned to copy Western behaviour.

A sense of identity

It is important to note that the term 'Pacific-born' or 'New Zealand-born' can be considered an insult.

A doctor's thoughts and questions should revolve around how a person was raised, their environment, life experiences and values. Through conversations with the patient, the doctor will gradually get to know them, but be aware that – as for the rest of us – the patient's sense of identity and self-knowledge may change over time.

*I am a Samoan – but not a Samoan
To my aiga in Samoa, I am a palagi [foreigner]
I am a New Zealander – but not a New Zealander
To New Zealanders, I am a bloody coconut, at worst,
A Pacific Islander, at best,
To my Samoan parents, I am their child.*

While this verse relates a Samoan experience, it encapsulates the paradox of identity for many New Zealand-born Pacific peoples. In many Pacific Island communities they are 'not Pacific enough'; rather they are seen as wanting to be European. In the wider New Zealand community, Pacific Islanders are often identified not as being New Zealanders, but rather as 'coconuts', or 'FOBs' (fresh off the boat). Some may develop a secure self-identity despite these perceptions, but others may experience confusion.⁴

Pacific Islanders with a broader ethnic identity in New Zealand call themselves PIs, Polys, or New Zealand-born. They have developed new music, fashion, customs and ways of speaking. This distinctive identity is sometimes referred to as Pasifika Aotearoa. Some young PIs are heavily influenced by Afro-American youth culture in their dress, slang, body language and music, especially hip hop and rhythm and blues. A unique culture has emerged within the Pacific people of South Auckland, who contribute culturally to the Ōtara market and the Secondary Schools Cultural Festival.⁶⁰

Interconnectedness

The cultural structure to which a particular Pacific patient belongs depends on a combination of geography, life experience, closeness to other families and kin, and maintenance of active lines of communication – often between countries. Pacific culture is extremely dynamic, and what is 'normal' is constantly being redefined.

Many modern urban Pacific families embrace connectedness, duty, obligation and mutual benefit within their daily lives. The problems of dysfunctional Pacific families, who are affected by drugs, alcohol, violence and/or sexual abuse, may be compounded by the complex interconnections, duties, reciprocities, and intricacies of wider family bonds and community obligations. These issues need be addressed in the wider community to be effective and acceptable.

Because of this 'interconnectedness', it is common for Pacific patients to bring family or friends with them to medical appointments, or to consult with them before accepting any treatment recommendations. Some people may feel more comfortable if another family member speaks on their behalf.

At times this can lead to a slightly longer interview so that the group can consult before making decisions, but as well as providing greater comfort to the patient, the presence of other relatives and community members can lead to improved care. For example, family members can provide additional background information during the medical history, and can help the patient to understand your instructions and carry out treatment.

Summary points – principles that guide culturally competent care

- There are often numerous differences between New Zealand-born and migrant Pacific peoples.
- Use of the terms 'Pacific-born' and 'New Zealand-born' can be considered insulting by some. Focus less on asking where a person was born and more on learning about their upbringing, life experiences, beliefs, and values.
- Pacific culture is very dynamic, and what is 'normal' is constantly being redefined.



Ethnicity data collection and use

Collecting ethnicity data accurately and consistently is essential to providing the best clinical care. Without this – and information such as educational level, religious affiliation, lifestyle, marital status, and dietary habits – health providers will be unable to provide individually-based care.

Doctors should make it a standard part of their practice to ask every patient what their ethnic background is; do not make assumptions based upon skin colour, name, or appearance. By asking the question, show respect for the patient's individual heritage, but also have an opening to discuss their cultural preferences.

For all patients, explain why, how and when background information will be used, and reassure them that, like all medical information, the information is treated as confidential. It is also critical not to argue with or challenge the patient's view of their ethnic affiliation.[§]

Some patients may identify themselves as being multi-ethnic, such as Samoan/Irish/Māori or Tokelauan/Niue, while others of Pacific ancestry may choose not to. However, if you ask questions in a consistent manner, explaining yourself fully and giving the patient enough time to answer, it is unlikely that anyone will find a question about ethnicity inappropriate or offensive.

In fact, you may find that your patients welcome the opportunity to share how they see their cultural heritage and their health interacting. For example, if a patient were to say, 'Oh, my family's Samoan (or Tongan or Italian or Māori), and food is an important part of family life, so there's no way I will ever not be overweight. There's nothing I can do about it', you could listen and then offer nutritional advice that is still culturally sensitive, or suggest an exercise programme that could counteract dietary indiscretions.

'BUT YOU DON'T LOOK...'

A case study on assumptions

Dr Bauer has recently joined a practice that routinely gathers ethnicity data on all patients. Dr Bauer hasn't done this in the past and he thinks it is rude and potentially offensive to ask such a thing. He prefers to make an educated guess based on the patient's

appearance, name, occupation, behaviour, and conversation, and he prides himself on rarely being wrong.

He has just finished seeing a new patient, Mrs Garcia, when she glances over at his notes and comments, 'Oh, Doctor, you have my ethnicity down wrong. I'm actually Samoan.'

'Really?' he asks in surprise. 'But I assumed you were European. Your surname –'

'My husband is from Spain; I'm not.'

'I see. Well, I must say, you don't look like a typical Samoan.'

Mrs Garcia frowns at him. 'Yes, I get that a lot, but I must say I don't appreciate it. In my family, we're very proud to have Chinese, English, Māori, Samoan, and Tongan ancestry, but I really consider myself Samoan.'

'I'm sorry. I was making some assumptions, and I appreciate your helping me to recognise that. It sounds like your family has a great deal to be proud of. There must be some fascinating stories that your older relatives can tell.'

Mrs Garcia smiles. 'Why, thank you. Yes, I am very lucky.'

Knowing that Samoan women are at a disproportionately high risk for certain conditions, Dr Bauer discusses this with Mrs Garcia and they agree to run a few screening tests.

Summary points – collecting and using ethnicity data

- Collecting and using ethnicity data accurately and consistently is essential to providing high quality medical care.
- Make it a standard part of your practice to ask every patient about their ethnic background; don't make assumptions based on name or appearance.

[§] Reported examples such as 'You don't look Samoan to me' or 'But you have blue eyes – how can you be Tongan?' should be avoided.

The central place of effective communications

Cultural competence can improve communication between you and your patient to achieve the best possible health outcome for the patient.

Some communication styles associated with Pacific peoples include:

- paraphrasing or speaking metaphorically – for example, they might use ‘first house of baby’ for womb
- needing more time to express themselves
- adults tend to be highly verbal and respond well to animation, facial gestures, drama, and long, meaningful conversations
- enjoying humour.

It’s important to explain health-care information so that the patient understands the topic. Just because someone appears to speak ‘good’ English doesn’t mean they fully understand everything, especially complex health issues. Always check a patient’s understanding by asking them to repeat things back to you in their own words.

Family members can help you to make sure the patient has received enough accurate information and to check on any misunderstandings and disagreements. Many Pacific peoples feel that the patient’s role is to receive treatment, while the role of the family is to support the patient and negotiate with authority figures.

There are several ways to create time to speak with the patient privately. For example, you may need to ask a question about sexual behaviour, drug use or another topic that the patient may be uncomfortable with or unwilling to discuss in front of family members. In that case, it is entirely appropriate to ask family members to step outside while you do this. If you feel this would be inappropriate, you can also wait until you are alone with the patient for another reason and ask them.

Summary points – culturally competent communication

- Cultural competence can enhance communication between your patient and you.
- Do not assume that speaking ‘good’ English is synonymous with understanding explanations about complex health topics; always confirm a patient’s comprehension by, for example, having them explain the treatment plan in their own words.
- Many Pacific peoples feel that the role of the family is to support the patient by interacting with the physician, while the patient assumes a more passive role.
- Do not assume that silence means consent.
- Politely require that your patients ask you questions and/or share their thoughts and opinions. Without this encouragement, many Pacific peoples will feel it is inappropriate or rude to express their concerns or disagreement to you.

Guidance on Pacific preferences



Be guided by each patient and their family when it comes to individual cultural practices. If you make assumptions based on broad stereotypes, you are likely to end up embarrassing your patient, and weakening the doctor-patient relationship, rather than strengthening it. For example, rather than greeting all Pacific patients with a Samoan greeting, you can first ask them about their background and only then use the appropriate greeting.

While most patients appreciate your efforts to put them at ease by acknowledging their culture and showing your respect for it, they are less likely to be appreciative if you misidentify their culture. For example, if your patient is a Tongan woman married to a Samoan man, you might assume from the surname that she is Samoan, but she might prefer to be greeted in Tongan.

It is important to be aware of gender issues and the evolving nature of society when working with Pacific peoples.⁵ The following examples are typical issues that may be important to a Pacific patient; they are not meant to suggest that every person of Pacific culture will feel the same way about any or all of these.

Initial contacts and protocols

The key to interacting with Pacific peoples is to build a connection that allows open communication.

Taking the time at the first meeting with the patient (and their family) to let them learn about the practice team will lead to more effective relationships. Practice team members should

introduce themselves when they first meet a Pacific patient and explain the job they have within the practice. This includes the reception staff who, after establishing these connections, could then explain after-hours arrangements, how to make an appointment, and how to pay medical fees. A small investment of time at a first meeting and during future visits will pay off in a longstanding, close relationship with not only the patient but their whole family.

You might spend a few minutes at the start of every appointment catching up with your patient about their family. By doing so, you are acknowledging those relationships, the importance they have to your patient's life, and your understanding of connections in Pacific culture. You will be re-establishing and building the doctor-patient relationship, before you move to the clinical part of the consultation.

'WHAT DID YOU CALL ME?'

A case study about pronunciation

Dr Jones is a GP who has recently begun working in an area of Auckland with a large Tongan population. She would like to develop close relationships with her patients and encourages them to call her 'Dr Anna'. She in turn calls them by their first names. She is unfamiliar with many of the names but is concerned that showing her ignorance would be offensive, so she pronounces them as best she can, assuming that her patients will correct her if necessary.

One day, she meets a new patient, 'Alo, an 18-year-old Tongan man who was injured at his workplace. He turns up with several members of his family. She greets him by name, calling him 'Alo. She notes that he becomes quiet and several of the younger children snicker, but no one says anything to her, and she assumes he is simply shy.

To put him at his ease, she uses his name often during the conversation and tries to make eye contact, but as the consultation progresses, the patient becomes more withdrawn. Despite numerous questions to him, it is difficult to get anything but very short answers, and she ends up speaking mostly with his mother. Dr Jones decides that, like many Pacific men in her experience, he simply isn't interested in taking part in his own health care.

It is only after the patient and his family have left that Dr Jones mentions 'Alo to one of the practice nurses, who is also Tongan. The nurse exclaims, 'Oh, dear – is that how you pronounced his name?'

'Yes,' answers Dr Jones blankly.

'In Tongan, the name 'Alo is pronounced like the words "a lot" without the "t", but the word alo – pronounced like the word "halo" without the "h" – means a bad smell. Did you ask the patient how to pronounce his name?'

'No, but why didn't he correct me? That's what I do when someone mispronounces my name.'

'In Tongan culture, it would have been very rude to correct you, since as a doctor you have a high status. But that also means that you have the responsibility to make sure that he feels comfortable sharing things with you. You could have made a "polite demand" that he correct your pronunciation or share any concerns with you. That would have given him the chance to explain the right way to say his name.'

Dr Jones is very upset at how she accidentally insulted her patient before his entire family. She asks her nurse to coach her on the proper pronunciation of the patient's first name and surname, then calls him to apologise and explain her error. The patient was surprised but pleased by the apology and, at her request, he promised to help her improve her Tongan

at his next appointment by teaching her a simple expression like 'hello' or 'thank you'. Confident that 'Alo won't be reluctant to attend his follow up because of her actions, Dr Jones nevertheless sends him a quick note, repeating her apology in writing and telling him that she's looking forward to seeing him at his next appointment.

When 'Alo appears, along with his family, for his follow-up, Dr Jones repeats her apology before the entire family, but it's clear that it has now become very much a funny family story to them, and not a source of offence. Before long, even the children are helping Dr Jones learn Tongan phrases, and her acceptance in the community is assured.

Pacific pronunciation and communication

Few Pacific patients have access to Pacific health providers, and the different cultural backgrounds between a doctor and their patient can hamper communication. This difficulty can be lessened by developing a understanding of Pacific language and communication. Learning how to pronounce Pacific names correctly is a great way to show respect for your Pacific patients.

If you are not sure how to pronounce a Pacific name, it is best to ask the patient first rather than trying to pronounce it and then asking if you got it right. It is better to admit your difficulties with Pacific names and ask for the patient's help, then, with their coaching, to attempt their name. This approach shows respect for the person and their heritage, as well as an interest in learning more.

While Pacific peoples' languages are very similar, there are varying ranges of pronunciation. Samoan pronunciation is very simple, and consonants are almost nearly identical to English consonants. The Samoan word for 'thank you,' – fa'afetai – is pronounced 'fah-ah-faytie'. The Samoan 'g' sound can be difficult for some foreigners to master. It's pronounced similarly to the 'ng' in 'sing along'; for example, the Samoan word for gun – faga – is pronounced as 'fah-ngah. The 'n' sound is also pronounced as 'ng' by Samoans. In Samoan words, all syllables are given equal timing with a slight accent placed on the second to last syllable.

Some common Samoan greetings and their English translations are: talofa – hello; fa’afetai – thank you; tofa – goodbye; lau susuga – sir.

Pacific peoples may be less likely to challenge treatment plans or ask questions than many non-Pacific patients, but their silence doesn’t necessarily mean understanding or agreement on their part. This, coupled with the shyness which is common to many patients before a health practitioner, makes it vital that you fully explain:

- what you are doing and why
- what you believe is wrong with the patient
- how you recommend treating the condition
- what medications you are prescribing and why (along with how they should be taken)
- what results (both positive and negative) you expect.

Do not wait to be prompted about this; make it a basic part of your discussions with the patient. Then be sure to ask whether the patient (and their family) have understood what you said and whether they agree. It is important to be sure that the answer you think you are getting is the one that the patient really means.

FINDING OUT THE UNDERLYING PROBLEM

A case study about communication

Mrs Vahalahi is a Niuean woman in her late 60s with diabetes. Her former GP, with whom she had a very good doctor-patient relationship, retired recently, so she found a new GP, Dr Lee, in her neighbourhood. At her first appointment, Dr Lee changed her medications. Mrs Vahalahi didn’t really follow his explanation of why he had done so, but she was reluctant to bother him or his nurse with questions.

The new medication gave Mrs Vahalahi diarrhoea, so she returned to Dr Lee. She didn’t feel comfortable talking about her diarrhoea with him or challenging his choice of medicine, so she simply asked if she could go back to her old medicine.

‘No, Mrs Vahalahi. I put you on the new medicine for a reason,’ said Dr Lee. He smiled to himself, thinking that older patients were very resistant to change,

even when it was change for the better. He knew he had done the right thing in putting her on the new medication, as the literature was very clear that it was the best choice for someone in Mrs Vahalahi’s situation and would give the best result.

‘Oh. All right,’ said Mrs Vahalahi quietly. She decided that she would just stop taking the medicine rather than deal with the side effects.

Dr Lee saw that Mrs Vahalahi didn’t look very happy. ‘Why do you want to switch back?’ he asked, curious. ‘What’s better about the old medicine?’

‘This new one, it upsets my stomach,’ Mrs Vahalahi answered. ‘I’m sure it’s a very good medicine, but maybe it’s not so good for me.’

Now Dr Lee understood. ‘No, you’re right, Mrs Vahalahi. A lot of people when they first get on this medicine have the same problem you do, but there are things we can do to improve that side effect. It doesn’t last very long either – your body just has to get used to it. Do you think you’d be willing to try the new medicine for a few more weeks? There’s such good evidence that this medicine can help your condition that I think it would really be worth the try. If you’re still having problems at the end of that time, I’d be happy to switch you back – I just want to be sure you’re on the best medicines possible, but I promise I won’t keep you on any pill that makes you feel worse.’

‘All right, Doctor. I’ll make that deal with you. Let’s see how I feel in a few more weeks.’

Lastly, be careful using medical jargon with patients.²⁶

This not only refers to specialised terms, like ‘myocardial infarction’ instead of heart attack, ‘cerebrovascular accident’ instead of stroke, or ‘adenocarcinoma’ instead of cancer, but also – and perhaps even more importantly – to ordinary words, such as ‘complain’, ‘deny’, ‘report’ or ‘claim’ that have a specialised meaning in a medical context. For example, a patient who overhears a nurse say to a doctor, ‘Mrs Faumuina is here, complaining of a headache for the last two days,’ may think that the nurse is accusing Mrs Faumuina of complaining, not recognising that she is using the word ‘complain’ in its medical sense. Similarly, a family may be offended if the doctor writes, ‘Family denies drug

use on the part of the patient', because they assume the term 'deny' implies disbelief on the doctor's part; if she had believed them, she would simply have written, 'Patient did not use drugs.' In all of these cases, a simple explanation will avoid or address hurt feelings.

Summary points – using Pacific languages appropriately

- Learning how to pronounce Pacific names correctly is an excellent way to show respect for your Pacific patients.
- Ask for help with pronunciation before attempting an unfamiliar name or word.
- Give everyday explanations for information such as test results or medication instructions, so that your patients fully understand their condition and your treatment plan, rather than relying on printed instructions.

Communication with Pacific families

It is very important that a medical team recognises that a Pacific patient may want family members to be involved in all aspects of their care and decision making. This involvement may vary across different families and cultures. It is not possible to generalise about how families wish to be involved with a patient's medical experience, so be sure to ask each patient what he or she prefers.

VALUE OF COMMUNICATION

A case study about checking assumptions

Mr Levu is a 58-year-old Fijian ex-smoker with heart disease. He has had diabetes for many years and was well-controlled on his medicine. Two years ago, he had a Coronary Artery Bypass Graft (CABG) and was started on insulin shortly thereafter. He also began inhaler treatment to maximise his pulmonary function. Since his surgery, he has separated from his wife and his HbA1C levels remain high (>15).

Dr Sino, a Samoan intern, has spoken with Mr Levu about his illness and marital separation, and the change in his diet and lifestyle now that he lives with his sister. Mr Levu has been counselled to take his medication, but nothing seems to help.

Dr Sino asks her practice nurse, who she knows has a close relationship with Mr Levu's family, for her views on the case. The nurse says that Mr Levu told her that his surgery had gone very badly and he was expected to die soon. Mr Levu is understandably very upset about this.

Dr Sino is astonished. The CABG was very successful and she is not sure why Mr Levu feels he is less healthy than before. She had assumed Mr Levu was as pleased with the results of the operation as she and the surgeon were.

Dr Sino sits down with Mr Levu and reassures him that he is not dying, but that the new medications and surgery have actually helped to improve his health and give him the ability to do more things. After several more discussions like this with Mr Levu and his family, within four months Mr Levu's HbA1C drops to 6.2.

Examining patients

As in many cultures it is polite to ask permission before touching or examining a person. After introducing yourself to the patient and any family members present, you should, before beginning any physical examination, explain briefly what you will do, why you are doing it, and ask permission to go ahead. Be aware that, depending upon the examination, some family members may choose to stay with the patient. You should ask the patient and family what they prefer, rather than automatically asking family members to leave the room (or to stay behind) while you make your examination.

Pacific patients may wear an adornment. If so, only remove it if it is a safety hazard. It may be better to tape it in place than to remove it; ask about this. If the adornment poses a risk to the patient or the medical team, ask permission from the patient and/or family before removing it and, if possible, allow a family member to remove the adornment and keep it safe.

Physical contact

In Pacific cultures, there are varying beliefs about physical contact between the patient and physician. Explaining and discussing practices clearly and in advance will help to put people at ease and to determine what is appropriate for each patient.

Body language

Body language can be different between Pacific and non-Pacific peoples. An example is the lack of eye contact a doctor may experience with a Pacific person. In many Pacific cultures, continued eye contact can be a sign of disrespect, especially when this involves gazing at authority figures such as doctors and nurses in a medical practice or hospital. Don't assume that a lack of eye contact shows disinterest or annoyance. Similarly, it may be better for you to avoid prolonged eye contact with Pacific patients as that may make them feel uncomfortable, as if they are being scrutinised, criticised or challenged.

Although lack of eye contact could be a sign of respect, it could also be due to anxiety, anger, boredom, inattention, or fear, just as with any other patient. You will need to look for other signals from the patient (or their family) to decide what is happening in a particular case. If you are unsure about this or any other non-verbal signal, ask the patient: 'I'm concerned that I might be doing or saying something to make you feel uncomfortable. Can you tell me what you are thinking?'

While direct, sustained eye contact may be off-putting to some, turning to face the patient (even if direct eye contact is not made) will show your wish to establish a connection. *The Pacific Island primary health care utilisation study* found that if Pacific patients felt that their consultation was hurried, they equated that with a lack of interest on the part of the GP.⁴⁰ Make sure that your body language shows a willingness to take the time to get to know the patient. Placing yourself side-on to them so that you can at the same time type notes into your computer, could be taken as showing a lack of interest and attention, if not as outright rudeness.

NONVERBAL MESSAGES:

A case study about body language

Ms Ward spent several weeks trying to find a doctor for her elderly Niuean mother, Mrs Pavihi, after her mother's long-term doctor retired. She finally found Dr Smith, who seemed to be perfect. She came highly recommended, had impressive credentials, had a practice near Mrs Pavihi's home, and had extensive office hours.

She wasn't able to accompany her mother to the first appointment, but asked her about it later that day. 'Did you like Dr Smith, Mama?'

'I don't think I'll go back. She doesn't know very much.'

'What do you mean? She's a very smart lady. Everyone says she's a good doctor.'

'I don't see how she can be. She never even looked at me. She just looked at her computer screen and tap-tap-tapped away, making notes. She never even turned away from the machine and faced me! She never paid any attention to me or what I was telling her.'

'She didn't spend any time asking about me, just wanted to know about my bowels and my heart and all my other parts, as if that tells her anything about me. She only wanted to know about the sick parts of the body; she didn't want to know about me.'

'Besides, everyone in that office was running around. Rush, rush, rush! I barely had time to take my coat off and they were hurrying me from one place to another. They must have too many patients – they can't spend any time with the ones they have, let alone meet new ones. I want a doctor who will get to know me and how I am doing, not just ask me about my sugar and my heart!'

Sharing information and consent

Since many Pacific people consider their own health problem as a community problem, they may feel threatened if their family members are excluded from medical interactions, consultations, decisions, or procedures.

Give patients the chance to tell you who they would like to have present and how much information they would like you to share with the others. Be guided by the patient's preferences, rather than by general notions about overall Pacific (or non-Pacific) culture.

There are times when you will need to be discreet, particularly when using family members as interpreters. While this may be convenient, it can also create problems. For example, using an abusive husband as the interpreter for his wife may make it impossible for you to discover the underlying abuse. Another example might be the impropriety and discomfort caused when asking a New Zealand-born grandson to translate for his grandmother when she wishes to consult you about a gynaecological disorder.

With informed consent, Pacific peoples are like all other patients in needing as much information as possible, often presented in several ways. Also, they may wish their family to be given the information, and to have the chance to discuss the matter with them before giving consent. Silence may not mean agreement, so when getting informed consent, be sure to ask about the patient's understanding and bring out concerns with open-ended questions.

'WHO WANTS TO KNOW?'

A case study about privacy

Mr Taorangi is a 60-year-old Cook Island Māori man who is hospitalised for a prostatectomy. His daughter is a nurse in the Cook Islands, and she telephones the hospital for information. Unfortunately, the staff on the hospital ward refuse to give out patient information and refuse the daughter's request to 'ask my father. He's right there and will give his consent.'

Because Ms Taorangi is a registered nurse, the family was relying on her to advise them about what was happening. She needed the information about her father's condition to do that. Although Mr Taorangi speaks 'good' English, this is deceptive, as his understanding, particularly of medical English, is not

very strong. The medical staff, however, misjudged his comprehension and tended to interact only with him, rather than speaking with other members of the family, including his daughter.

It took several phone calls before Ms Taorangi was able to make her father's doctors understand the situation. Once that happened, and she was given medical updates, she could then reassure her parents and make sure they understood what was happening. She was also instrumental in helping the medical team set up a post-operative care plan.

Often Pacific families will nominate the most health-literate member of the family to interpret or advocate for them and the patient. It is helpful for doctors to communicate with this person to make sure that there is good understanding on both sides. Letting the family spokesperson know the timeframes in which you require a decision, or in which certain activities will take place, can avoid frustration or confusion on both sides.

When using an interpreter, speak directly to the patient, so that you can read their body language and emotional responses. Prompt the interpreter (especially if this is a family member and not a professionally-trained interpreter) to ask the question just as you say it.

Summary points – communicating clearly when giving information and seeking consent

- Some Pacific peoples may feel threatened or abandoned if their family members are excluded from consultations or procedures. Be sure to ask about the patient's preferences.
- Remember that silence doesn't necessarily mean consent.
- Some Pacific families may choose to appoint one person as advocate or liaison for them and the patient. It is usually very helpful to work with this person to ensure good communication and trust.

Traditional medicine

Traditional Pacific medical practices not only deal with medicinal plants and their uses but also with the physical, emotional, mental, and spiritual welfare of the person. Traditional healing practices help cure life's everyday ailments and common injuries.

Traditionally, Pacific peoples believe that life is the union of body, emotions, mind, and soul or spirit. Health is a state of balance of several opposing aspects within the human body, as well as between the human body and the environment. Illness happens when a person falls out of balance physically, emotionally, mentally or spiritually.

Traditional medicine approaches diagnosis and treatment holistically. It considers a person within an ecological context and usually will not simply look after the sick part of the body. As well as providing treatment, practitioners of traditional medicine often give advice on lifestyles and healthy behaviour.

Traditional medicine is based on individual needs. Different people may receive different treatment, even if they suffer from the same disease. Traditional medicine believes that each person has his or her own constitution and social circumstances, which result in different reactions to the 'causes of diseases' and treatment.⁶⁶

The traditional healer

In ancient times, most Pacific peoples believed that supernatural forces caused illness. If a person got sick, it might be thought that a spirit was displeased with their behaviour, or that of one of their relatives. It might be thought that they were suffering from hidden guilt or a secret wrongdoing. It might even be suspected that another person had cursed them. The person and the traditional healer might also decide that the patient had broken a taboo, eaten unwholesome food, or suffered from too much emotional or sexual passion.

When a sick person went to a healer, the patient would review their recent actions to try to determine what might have given offence. The patient would describe any symptoms to the healer, who would perform or direct proper corrective measures. This might have included a special diet to bring about a state of balance in the person.

Historically, Pacific peoples did not consider biological agents such as bacteria and viruses as the causes of disease. A Pacific person always tried to discover the nature

of the offence which caused the illness. So-called 'incurable' diseases that resulted in death were believed to be under the control of the gods, and whether a patient recovered or died was dictated by the superior will and desires of the gods.

Current traditional practices

Massage involving the whole body (or parts of it) is one of the most commonly used medical treatments throughout the Pacific. Massage treatments are used to cure headaches and muscular pains, to tone the body after childbirth, to correct a clubfoot and other malformations, to ease healing sprains, and during pregnancy.

All Pacific cultures have a healthy appreciation for bathing, whether in fresh water or the sea. People wash frequently, and might use certain leaves which lather like soap, rub sand in their hair to clean the scalp, remove grime from their skins with oil, and use wadded fibres from coconut husks and other plants to scrub their bodies.

Healers throughout the Pacific use plant medicines in the form of potions and applications. Most commonly, they prepare medicines from selected plants by pounding the material in a wooden bowl and straining the juice. Sometimes the juice may be sweetened with sugar cane sap and drunk with water, inhaled or applied to an injury.⁴⁵

Some Pacific cures

- *Pacific peoples use smooth stones and shells in massage, and to relieve stress, tension, aches, tiredness, muscle strains, and general unwellness.*
- *In Tahiti, to relieve pain and infection, soft mud is smeared over scalds and superficial burns and allowed to dry in place.*
- *In Tahiti and Samoa, breast milk is applied to the eyes to rid them of conjunctivitis.*
- *Fijians may use urine on bee and jellyfish stings to stop the pain and itching.*
- *Kava is crushed and drunk to relieve headaches, tension and sleeplessness. A kava poultice is also used in Hawaii to stop toothache.*
- *Fijians and Hawaiians may use turmeric root, which is cleaned, then pounded and mixed with hot water, strained and squeezed to produce a juice used to relieve diabetes and coughs.*

- *The cut end of the stem between a taro corm and leaf is rubbed onto insect bites to reduce itching, pain and swelling.*
- *Raw kukui or candlenut is eaten as a laxative in Hawaii.*
- *In Tonga, women scrape tree bark to get sap which they apply to the tongue and mouth of children to treat thrush.*
- *Fresh green ti leaves are directly applied to the forehead to cool the brow and relieve headaches.*
- *The juice of the moist husk of green coconuts is squeezed and administered to newborn babies to clear their systems of 'womb' food.*
- *Coconut oil scented with fragrant leaves and flowers is used in massage for aches, pains, injuries, vitality, and beauty.*
- *The people of Rapa Nui (Easter Island) use sweet potatoes to quench their thirst. Hawaiian women may use sweet potato vines as a necklace to ensure an abundant flow of breast milk.*
- *Samoans may apply urine to eliminate styes in the eye.*
- *Throughout the Pacific, people use the juice of the noni for its curative powers.*

A potential problem with traditional Pacific medicine is that it can be seen as 'victim blaming' and may bring about shame in the patient and the family, because of the link between illness and inappropriate behaviour by the individual or family member. This can be particularly difficult for the family, since many medical conditions are not the result of moral wrongdoing or the breaking of social tapu.

The Western medical diagnosis can at times be very liberating for Pacific patients and their families. The patient and their family may prefer the medical explanation may be preferable to the patient and family, as it does not cause feelings of guilt or shame. However, it is extremely important for doctors to give honest reasons for their diagnosis, without belittling traditional beliefs held by a patient or family.

Whether your patient believes that their illness is due to a violation of tapu, clogged arteries, misaligned chakras, insufficient vitamin C, or evil spirits, your role is not to challenge their belief but to work with them to help them be as healthy as possible. If their beliefs are dangerous or make successful treatment impossible, it is appropriate to share your concerns and seek a compromise. Doing so in a respectful way is more likely to succeed than being argumentative, condescending, or patronising.

WORKING WITH EACH OTHER, NOT AGAINST EACH OTHER

A case study about traditional medicine

Mr Apa is a 19-year-old Samoan man who is losing his vision. He has had two operations, but his loss of sight continues to progress. After his second operation, his mother contacted a Taulasea (traditional healer) and insisted that Mr Apa consult him. Knowing that the Taulasea would apply different formulations not only to his eyes, but to his ears as well, Mr Apa asked his specialist, Dr O'Connor, for his opinion.

At first, Dr O'Connor was taken aback, assuming that Mr Apa was seeing the Taulasea because he had lost faith in Dr O'Connor's skill. He was tempted to point out that the traditional remedies were not based on any kind of evidence, that the formulations were not made to any kind of quality standard, and that it was possible that the substances would interact negatively with the eye drops he had prescribed for Mr Apa. However, before he shared these concerns, Dr O'Connor asked Mr Apa about the role of Taulasea and how they had helped him and his family in the past.

Mr Apa replied, 'Well, Doc, I'm not sure I believe that they'll work, but my mother really does. And besides, you see loads of advertisements for herbs and supplements these days and at least the Taulasea's remedies have been used in Samoa for generations. Like I say, my mum really believes in the traditional medicines, and she worries that my not trying them is part of the problem. She doesn't mind my using Western medicine too, but she thinks the two systems can work together to save my eyes. She says that I walk in both worlds, so treatments from both worlds should be used to help me. Plus, it's really important that I see the Taulasea for my mother's sake – so that she is seen by the community and the rest of our family to have tried everything for me. Our community might think she isn't taking good care of me if we don't try every cure available.'

Pleased to learn that Mr Apa has not lost faith in him and that in fact he feels comfortable enough to share his fears and concerns, Dr O'Connor explains, 'Well, Mr Apa, I can certainly understand how you feel. I have relatives who rely on treatments that aren't based in Western medicine either, and they, like your mother, feel they get good results with them. I think it's fine that you see a Taulasea – if it were my vision, I'd want to be sure that I wasn't overlooking anything either. I do have a few concerns, though. Some natural substances have the potential to interact with Western medicines, and I want to be sure I'm not giving you anything that would react badly to the traditional medicine, and that your healer isn't giving you anything that might react badly with what I give you. If you can make sure that we each know what the other person is doing, then I think there will be no problem with you seeing both of us.'

Summary points – traditional Pacific health beliefs

- Ancient Pacific beliefs attributed illness to supernatural forces rather than biological agents. Pacific peoples may feel responsible for their illness/injury and/or may consider that a stigma is attached to their condition.
- Massage is a common Pacific medical treatment; another is plant-based remedies.
- Never belittle a person's traditions or concepts of health. Work with the patient and family on the best way to use both modern Western and Pacific medicines to help the patient.