

# 11 Cultural competence and patient-centred care

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Cultural competence – a consumer perspective

Cultural competence – the requirements

The HPCAA

The Medical Council of New Zealand

The Code of Health and Disability Consumers' Rights

Cultural competence and the context of New Zealand society

Recognition of the importance of bicultural heritage and development

Encountering New Zealand society

Is cultural safety a better term for a patient-centred approach?

Cultural competence: patient-centred and family-centred approaches

Cultural competence – an ongoing journey

## Cultural competence – a consumer perspective

As a patient I feel vulnerable and I find it hard to feel empowered even as a knowledgeable and assertive person. Although I was born in this country, have always lived here, and I am from the 'dominant' culture, the health environment often still feels strange and alienating to me even though I know a lot about it, including my rights as a health consumer and how to follow up on any concerns that I may have. I feel nervous about what I don't know and also what I do know from my own past experiences and the stories I have heard from others. I have also personally experienced and heard about many excellent health experiences but somehow the not so good ones are often more prominent in my mind. I am aware that it can be far more difficult for patients with less education, whose culture is far removed from the context they are in, for those who feel judged because of how they look, act or because of their lifestyle, for those who don't have English as a first language or who barely speak English at all, and for many of those who can no longer speak or act for themselves...

What then is important to myself and other patients in receiving culturally competent patient-centred medical care? This is not an easy question to answer simply, and certainly not on behalf of others in all their diversity. It is questionable whether I should even attempt to speak on behalf of others. However in my roles as a lay member or health consumer representative I am attempting to bring a strong and inclusive (but reasonable) consumer voice. Therefore I will attempt to do this.

We patients need you, our doctors, to develop a general and interconnected set of attitudes, behaviours, knowledge and skills that enable you, to be non-judgemental and show us respect and understanding, to be approachable, and to communicate well. We want you to behave in ways that make us feel safe, assist us to ask questions and give feedback about any concerns we have, and we want to be listened to. If our requests cannot be accommodated we want you to be honest

with us about why this is. It is helpful when you are friendly, and pronounce our name correctly or at least talk with us so that you can learn how to do this. We appreciate it when you show humility and assist us to tell you if there is any cultural need we may have that you are not aware of. If it is possible, help us to ensure that any important cultural requirements we have are accommodated. As a general rule we want to be active partners in our health care decision-making however in some cultural contexts we may not want this and we may not find it easy to communicate this to you. If we do not understand you we may find it hard to tell you this and in some cultural contexts even nod as if we do understand. We hope that you do not label us as non-compliant or difficult but work to find ways to understand our reality and adapt to this.

We also need doctors to engage well and in a culturally competent way with our family and other support people when this is appropriate. We hope that our doctors are culturally sensitive in all aspects of their work with us, not just to our face, and when we are conscious. Cultural competence also needs to extend beyond the patient to apply to interactions with colleagues and others encountered in the health environment to help ensure safe, collaborative and supportive health systems are in place around us. Cultural competence involves the heart as well as the intellect. We can teach you a lot if you are open to this.

General cultural competencies must be recognised as significantly more important than developing a range of cross-cultural knowledge about specific ethnicities and cultures. If you manage to achieve this as well it could be very helpful unless you embarrass and undermine us by knowing more about our culture than we do – but then this would not be our lived culture. If you are not able or are too busy to meet absolutely all these needs we hope you will help to develop and support health systems that can. Is this too much to ask?

## Cultural competence – the requirements

### The HPCAA

One of the additional provisions for health regulatory authorities introduced under the Health Practitioners Competence Assurance Act 2003 (HPCAA) is that of setting the standards of cultural competence to be observed by health practitioners. This is included under section 118(i) of the Act.<sup>1</sup>

### The Medical Council of New Zealand

After a lengthy consultation process involving the profession and the public, the Medical Council of New Zealand (the Council) released a general statement on cultural competence in 2006<sup>2</sup> alongside a statement on best practices when providing care to Māori patients and their whānau.<sup>3</sup> A resource booklet prepared for the Council by Māuri Ora Associates on practice implications with Māori patients and their whānau<sup>4</sup> was also released at this time. These statements provide guidance to the profession in developing cultural competence both as individual practitioners and in their broader contexts, for example, through practitioner groupings such as the specialist branch advisory bodies. Further assistance is planned with work currently underway on a resource booklet to assist doctors when providing services to Pasifika patients and their families.

The Council defines culture broadly - extending beyond ethnicity and recognising that patients identify with multiple cultural groupings. These include (but are not limited to) gender, spiritual and other belief systems, sexual orientation, disability, lifestyle, age and socioeconomic status.

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

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

### **The Code of Health and Disability Consumers' Rights**

The Code of Health and Disability Consumers' Rights (HDC Code)<sup>5</sup> includes rights that relate to cultural competence. Right One is about being treated with respect and includes the statement that *services should take into account your cultural, religious, social and ethnic needs, values and beliefs*. Right Two states that as a consumer *you should be free from discrimination on the grounds of age, gender, race, beliefs, marital or family status, employment, sexual orientation or disability*. Right Five states that *information should be given in a form, language and manner in which you can understand and that a competent interpreter should be available if you need one and if it is reasonably practicable*. Right Seven includes a statement that *you may make decisions about body parts or bodily substances* and this is of particular significance to some cultures including Māori.

## **Cultural competence and the context of New Zealand society**

### **Recognition of the importance of bicultural heritage and development**

The establishment of cultural awareness and competency concepts and training in Aotearoa New Zealand have usually incorporated an understanding of our bicultural heritage as a key understanding. This bicultural emphasis recognises Māori iwi (tribes) as the indigenous or first nation peoples (tangata whenua), and the people from the other (originally predominantly British) cultures (tau iwi), as the later colonisers. Te Tiriti o Waitangi, the Treaty of Waitangi of 1840, is recognised as the founding document between Māori iwi and the British crown on behalf of the later arrivals. Māori is an official language in Aotearoa New Zealand. Māori protocols and rituals of encounter have been incorporated into many health workplaces. Māori/iwi health services have been established throughout the country as have Māori policy, advisory and cultural services within District Health Boards (DHBs) and Primary Health Organisations (PHOs). ‘Treaty training’ is ongoing and an expectation of many health workplaces in Aotearoa New Zealand. Research concerning health disparities for Māori, and ways to address these, is important in the ongoing development to assist culturally competent practice with Māori.

### **Encountering New Zealand society**

There are numerous new challenges for overseas doctors in understanding the peculiarities of New Zealand society, and the context and processes involved with health care delivery.<sup>6</sup> In addition to learning about Māori culture there are Aotearoa New Zealand colloquialisms, humour and other shared cultural understandings to make sense of. There are cultural patterns to be aware of, for

example, many New Zealand men have a tendency to understate illness and may be reluctant to consult their doctor when unwell. It is important to recognise that illnesses, for example depression, may manifest differently for people of different cultures in the way symptoms are presented.

Aotearoa New Zealand is increasingly becoming more diverse with the number and range of different ethnicities and cultures increasing and with some groups, such as Asian immigrants, growing rapidly. All of these aspects are influencing the make up and expression of New Zealand as a society. There are also additional complexities to be considered, for example, the difference between Aotearoa New Zealand born Pasifika people and those who are island born.

### **Is cultural safety a better term for a patient-centred approach?**

Although similar concepts, nurses, some academics, educationalists and doctors assert that *kawa whakaruruhau*/cultural safety, the term introduced by Irihapeti Ramsden and adopted by the nursing profession, is preferable to the term cultural competence.<sup>7,8,9</sup> Both terms concern the relationship between the helper (health professional) and the person being helped (the patient) however cultural competence is frequently described as being more centred on the health professional's experience while cultural safety centres on the experiences of the patient. It is therefore argued that cultural safety fits better with a patient-centred stance. That is, the patient can and should determine what is culturally important to his or her needs. It is argued that health consumers are then able to become full partners in health care interactions, active in their treatment and are assisted to feel safe, respected and empowered. However the development of culturally safe practice requires health practitioners to establish, maintain and develop cultural competency. It can be argued then that these terms are intertwined. Competency requires safety and safety requires competency. A patient-centred approach needs to be central to both.

Concepts of cultural competence and cultural safety both also recognise the importance of culturally appropriate and respectful professional relationships with colleagues and staff and the responsibility health professionals have in challenging cultural bias within health care systems where this brings negative impacts for patients. Cultural competence involves working effectively with interpreters to enable and improve communication, and developing networks with individuals and organisations who can provide expertise to assist in better understandings of patients' cultural needs.

### **Cultural competence: patient-centred and family-centred approaches**

Patient-centred care places the needs of patients at the centre of health care interactions.<sup>10</sup> It means being truly 'present' with patients, aware of the values, biases, assumptions and expectations you bring and being able to question these while at the same time trying to imagine what it is like in your patients' situations. It involves engaging with difference, having the ability to listen without interrupting and with a willingness and ability to extend your understanding to assist your patients.<sup>11</sup> The ability to look back on your patient/doctor interactions, review these, consider how they might be improved, and develop awareness and knowledge for the future is important. This self-reflection (reflective practice) is an important ongoing activity when working for ongoing improvement in cultural and other competencies.

For many cultures and contexts family-centred approaches are important also as it is not possible to consider the patient without the wider unit of their whānau/family and extended family. In some cultures patients and their families may prefer a family-centred approach to care and this can mean family members taking the lead in decision-making.<sup>12</sup> There may be a preference for a paternalistic approach where doctors are expected to be the decision-makers. This preference is somewhat at odds in the modern healthcare environment influenced by for example the HDC Code and *Good medical practice*<sup>13</sup> and creates tensions that need careful management. If the cultural context indicates a family-centred approach, it is important to establish that this is what the patient genuinely wants and that they are not unwillingly being dominated by others. Some families are not a positive environment for patients and may instead be a danger to them. Traversing this can be fraught with tensions and difficulties. It is important to remember that each patient context is different and assumptions are never helpful.

### Cultural competence – an ongoing journey

Cultural competence is an ongoing journey - there is always more that can be learned. The key is being committed to the journey alongside patients, their whānau/families and other support people, and also when appropriate in the wider context of working alongside communities and health consumers to improve both the quality of services and health outcomes.

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