



**Te Kaunihera Rata
o Aotearoa**

Medical Council
of New Zealand

DRAFT FOR CONSULTATION

Statement on Cultural Competence and Cultural Safety

Introduction

Cultural competence and cultural safety are related but distinct aspects of a doctor's practice:

- **Cultural competence** is the cultural knowledge, skills, and behaviours that doctors need to operate effectively in Aotearoa New Zealand, to deliver high quality medical care and achieve health outcomes for all cultural groups.
- **Cultural safety** is what the patient experiences as a health care consumer, and requires doctors to reflect on how their own views and biases impact on their clinical interactions and the care they provide to patients.

Both cultural competence and cultural safety are essential to all aspects of a doctor's practice, including patient care, teaching, leadership and management, research, advocacy, and professional behaviour.

Cultural competence and cultural safety benefit all patients and communities. Common cultural groups in Aotearoa New Zealand include, but are not limited to, groups based on Indigenous status, ethnicity, gender, gender identity, sexual orientation, socioeconomic status, spiritual or religious belief, age or generation, migrant experience and disability.

In Aotearoa New Zealand, research shows clear inequities in health need, access to and quality of health care, and health outcomes for a variety of disadvantaged or underprivileged groups.

Culturally safe medical practice recognises and helps to address the determinants of health and wellbeing, the experiences, and the systems that contribute to health and social inequities. Developing cultural safety is one strategy to correct bias in health care delivery to improve health outcomes for patients and communities across multiple cultural dimensions.

Cultural competence

Understand how culture affects health

1. It is important that you understand how culture affects health in Aotearoa New Zealand.
 - a. Aotearoa New Zealand has a culturally diverse population. Culture affects how doctors and patients understand and experience health and illness, how health services are offered and accessed, and the effectiveness of health care interventions.
 - b. In Aotearoa New Zealand, health care system, institutions, and medical practice are strongly informed by the beliefs of the dominant culture. This means medical practice often does not align with Māori culture, or with the cultures of other diverse groups in Aotearoa New Zealand.

For example, the dominant culture can have approaches to engaging with patients and whānau or families that are not culturally comfortable for other cultures, and therefore do not build trust in the practitioner-patient relationship. Creating an environment where the patient feels culturally safe will increase the likelihood of successful assessment and treatment.

Be aware of your own cultural identities and worldviews

2. You must be aware of your own cultural identities, beliefs and worldviews and how these may affect your medical practice.
3. It is important not to assume that your worldview applies to others, and not to impose your cultural values and practices on patients and colleagues. This creates a safe environment for colleagues and patients to share information about their cultural identities and worldviews.

Take the worldviews of others into account in your practice

4. You should make every effort to recognise your patients' and colleagues' cultural worldviews and adjust your practice accordingly to achieve the best health outcomes. This may involve changing your communication style or your work processes to suit your patient's cultural identity (as defined by them).
5. You must work with people in respectful and non-judgmental ways. Avoid making assumptions about an individual based on their cultural identity; there is no single fixed or right way to belong to a particular cultural group. Seek to understand the difference between cultural appreciation and cultural appropriation, and the harms associated with appropriation.

Cultural safety

Examine your identity, culture, and dimensions of power and privilege

6. You must actively acknowledge and address your own power, privilege, biases, attitudes and assumptions that may affect the quality of care you provide.
7. You must recognise and respect diverse understandings of health, and the cultural practices relating to health, family structures and community supports. Patients of all identities have a right to equitable access to health care, equitable care and treatment, and equitable outcomes.
8. You must recognise how privilege and underprivilege affect health need, health care access, quality of care, and health outcomes. Some dimensions of identity result in power and privilege whereas others result in underprivilege, which can lead to discrimination or marginalisation. Most people, including patients and health professionals, live with one or more intersecting dimensions of marginalisation and social privilege.

Improving patient experience and equity of outcomes

Continuous improvement

9. Ongoing self-reflection, learning, assessment, and adapting and improving your practice are important steps to build your cultural competence and ensure you provide culturally safe care.

10. Remember that cultural safety needs to be defined by patients and their communities, particularly those from disadvantaged groups, so it is not possible to determine cultural safety through self-reflection alone.
11. Consider the use of objective measures and external sources of feedback to identify gaps in your knowledge, areas for improvement, and to monitor your ongoing development. It is important for you to identify when you need additional cultural expertise to help you deliver culturally competent and culturally safe care, and to know where to access this expertise. You are required to identify and address these gaps in your recertification activities.

Collect data to measure improvement

12. The collection of relevant high-quality data is critically important to measure equity in medical practice (for example, ethnicity data quality audits, outcomes data and patient satisfaction surveys). You have an obligation to comply with national data protocols.

Reduce bias

13. You should seek to recognise and reduce bias in all aspects of your medical practice, including in the delivery of patient care, teaching, management, workforce, research, and the collection and use of data.
14. Policies, processes, and structures in a practice environment can reinforce privilege and maintain disadvantage, or can enable change. Where possible, you should actively use these mechanisms to reduce bias and to enhance the cultural safety experience of patients and whānau/ family members.
15. You should be prepared to challenge the bias of individual colleagues and systemic bias within the health system. This requires recognising incidents of direct discrimination as well as indirect, subtle, or unintentional discrimination by other health professionals, colleagues, patients, or their whānau/family members. You should be aware of options to address these incidents. This can also include providing support to those who report experiences of discrimination or lack of safety.

Cultural load

16. While lived experience can often offer a valued additional skill-set in a team, it is also important that you acknowledge and seek to reduce the cultural load on colleagues and patients from non-dominant cultural groups.

Appendix

Terms we use in this statement

Culture: a common pattern of human behaviour that can include thoughts, communication, actions, customs, beliefs, values, and institutions of an ethnic, religious, or social group.¹ Culture is dynamic, mobile, and changes according to time, individuals and groups.² Culture is more than just ethnicity, and patients and colleagues may identify with multiple cultural groupings at any one time.

Cultural competence: the cultural knowledge, skills, and behaviours that doctors need to operate effectively in Aotearoa New Zealand, to deliver high quality medical care and achieve positive health outcomes for all cultural groups.

Cultural safety: is what the patient experiences as a health care consumer. It requires doctors to engage in ongoing self-reflection and hold themselves accountable for delivering culturally safe care, as defined by patients and their communities, and as measured through progress towards achieving health equity. It requires doctors to actively challenge their own bias and that of others, recognise and address power imbalances, uphold the mana (status or authority) and autonomy of patients, and be responsive to the cultural, historical, and social contexts of patients and whānau.

Cultural appreciation: a way of honouring another culture through exploration and seeking an understanding to honour that culture, its beliefs, and traditions.

Cultural appropriation: the use of elements of one culture by members of another culture, in ways that are perceived as unacknowledged or inappropriate.³

Cultural load: The additional expectations on members of minority cultural groups (from colleagues or institutions from the dominant culture) to provide cultural knowledge, insights, translations, or other support. This additional workload may be unwanted, and without formal recognition or resourcing. There may also be responsibilities or expectations from within the doctors' community to represent, advocate, or provide knowledge or care.

Dominant culture: in Aotearoa New Zealand, this refers to the longstanding norms, assumptions, and practices that have shaped the design and functioning of institutions, including the health system.

The values and worldviews of settler traditions from the United Kingdom and western Europe were reflected in the formation of these public systems. Although not created by today's practitioners, their design and operation continue to privilege or advantage people who align with the 'norms' of that time, and disadvantage others who do not. These disadvantages can be seen in poorer health care access, experience, and outcomes for Māori, and for others based on differences of ethnicity, gender, disability, sexual orientation, class or socio-economic status.

References

¹ Cross TL. Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. CASSP Technical Assistance Center, Georgetown University Child Development Center, 3800 Reservoir Rd., N.W., Washington, DC 20007 (\$8.50). 1989. p. 90.

² Papps E, Ramsden I. Cultural safety in nursing: the New Zealand experience. *Int J Qual Health Care*. 1996;8(5):491-7.

³ Lalonde, D. Does cultural appropriation cause harm? *Politics, Groups, and Identities*. 2019;9(4):1-18. DOI 10.1080/21565503.2019.1674160.