President's Blog

August/September 2019

'Reflections on cultural competence, safety and health equity'

Germans are well known for being pragmatic and having a love of following rules. This extends to their language and I often find simple German words making their way into the English vernacular, either because English doesn't have a construct for that word, or the description of that construct is unbearably lengthy. One of the current oft in use words is Zeitgeist – and by now we all know Schadenfreude. Another personal favourite is 'Umweg,' the wonderful description of a detour that lengthened your journey (not always a vehicular journey).

I feel that the renewed enthusiasm for increased understanding and teaching of te reo Māori, the promotion of heightened cultural competency and a more mainstream awakening to ethnic privilege embodies a current Zeitgeist – 'a spirit of the age' as it were. Not in the sense that it will come and go, but in the sense that being 'woke' to this privilege is gaining traction in many quarters. There has been so much hard work to improve cultural competency over many decades – much of it pioneered at the forerunner to my own workplace (ADHB) and it is very much decades in the development, passing through many umwegs. Nursing practices underpinned by kawa whakaruruhau (cultural safety) are the embodiment of a commitment by nursing staff to Tiriti o Waitangi. Our Australian counterparts see us as light years ahead already, such is the woeful state of inequity for indigenous Australians.

Recent developments in New Zealand to enhance cultural competency and safety are underpinned by the tremendous and courageous work of many; Māori, Pākehā, Pacific Nations people to name just some.[1] Although between Bastion Point and Ihumātao, perhaps not that much has changed yet.

The Medical Council of New Zealand and the Australian Medical Council have been drivers of improvement. MCNZ has recently consulted on their updated Statement of Cultural Competence, which is a revision of the 2006 Standard that outlined "the attitudes and knowledge expected of doctors when providing care to Māori and Pacific peoples." The updated statement sees a shift towards the onus being on the physician to self-reflect and identify and manage internal biases. Working to reduce the effects of bias should be every clinician's concern, and the starting point is how we think and then translate this thinking into actions which influence the treatments that we recommend or undertake for patients. The impact of better understanding (and managing) our internal biases should not be underrated – ultimately it should lead to improvements in how doctors interact with and treat all patients, regardless of ethnicity, social background, gender, sexuality, skin colour or any other 'differing' factor.

These shifts from the Medical Council, possibly described by some as 'motherhood and apple pie' statements, are crucial to improving the vast health inequities experienced by all minorities when compared to the standards experienced by those of us who fulfil 'cis'/majority criteria. However, as an anaesthetist/anaesthesiologist, I am left to ponder the question of how. How do I implement my learnings on subconscious biases with my patients? There are simple measures I can take, e.g. correct name pronunciation, learning different greetings (both verbal and non-verbal greetings), and keeping items used for heads separate from those used elsewhere (hence the blue pillowcases for heads in my department). But how do I influence the bigger health inequities experienced by my patients? I don't select who gets offered surgery as we are, by and large, not net generators of work. Your ideas and suggestions are welcomed.

I have talked to Māori medical practitioners about this issue. One of the surgeons I work with is heavily involved in his college's shift towards addressing health inequities among indigenous patients, and his own stories about ongoing land conflicts and the deep effects of Māori disenfranchisement are heart-breaking. He notes that the World Health Organisation outlines 'poor

adherence' to chronic therapy as a multifaceted issue.[2] It should not be seen as purely a patient issue, but one that both the provider and patient have roles in. There are systemic issues in this country that can make it more difficult for all patients, but especially non-Pākehā patients, to adhere to treatment regimens.

As an executive, we have been discussing adding a Māori name to the Society's English name. This is in keeping with many other Societies and Colleges in New Zealand. For me, it is about acknowledging the underlying bicultural nature of this country and is a move towards recognising that fluency and communication in te reo should be normalised. One view is that it could be seen much like the French-English bilingualism of Canada. Although those carrying the burden of inequity in Canada are First Nations people and not the French. I think a wider remit is required when seeking to find an appropriate Māori name. I would like it to reflect a deeper commitment to improving health inequity, i.e. for the NZSA to consider:

- advocating with inequity in mind
- bringing the anaesthesia community together, making sure we are inclusive to all ethnicities
- educating our office, our executive and our members on implicit biases and ways to mitigate them.

And yes, fundamentally, I do agree with all children being taught te reo at school. I enjoy being bilingual and being able to speak German fluently, and deeply wish I had the same ability in both the official spoken languages of my native country.

For me, learning German added a lot to my understanding of English, not just the grammatical constructs or vocabulary, but how language reflects culture. During a welcome to country ceremony at the Combi SIG meeting in Manly, the Indigenous presenter informed us that in his language, there is no word for disability. I thought that was striking. I'm not sure the Inuit really have a hundred words for snow, but culture certainly shapes language and vice versa. Learning about other cultures enriches lives and an understanding of the language of that culture enhances this enrichment. Māori speak of the past being in front of you because it is known/can be seen. The future is behind you. A completely different viewpoint to the Anglo-Saxon one.

So, an understanding of our own biases and the constructs through which we view the world, and the fact that these are not universal but shaped by our own culture and experiences, is critical to moving forward and creating systems that work for more people. Systems that provide good outcomes to those coming from the most disenfranchised and impoverished populations are likely to give good outcomes to more affluent people too.

References:

1. Haami B, Bringing culture into care; a biography of Amohaere Tangitu. Huia Publishers 2019.
2. Sabate E. Adherence to long term therapies: evidence for action. Geneva: World Health Organization; 2003