Managing the cross-cultural consultation

The importance of cultural safety

Ben Gray

Correspondence to: ben.gray@otago.ac.nz

***Ben Gray** has been a GP at Newtown Union Health Service (NUHS) for the last 15 years, prior to which he worked in Waitara Taranaki. NUHS serves a diverse multiethnic population. He also works as Senior Lecturer and convenes the 'Professional Skills Attitudes and Ethics' course for Wellington Medical Students.*

ABSTRACT

'Cultural competence' is in the spotlight with recent documents released by the Medical Council and the RNZCGP. The RNZCGP document has a strong focus on better care for Maori, but the omission of any reference to the use of interpreters means that the needs of those who speak limited English are inadequately addressed. This article argues that we should separate out the two issues of 'The Treaty of Waitangi' and 'cultural safety'. The Nursing Council has made this distinction, largely based on the writings of Irihapeti Ramsden on cultural safety. It then describes what the author has learned about managing the cross-cultural consultation in an approach that is congruent with cultural safety.

Cross-cultural care is much more in the spotlight currently. The Medical Council of New Zealand (MCNZ) has recently released two guidelines: *'Cultural competence'* (CC) (MCNZ29) and *'Best practices when providing care to Maori patients and their whanau'* (BPPCMP) (MCNZ30). The RNZCGP has recently released *'Cultural competence'*. One appropriate focus of the MCNZ and RNZCGP documents is the impact of cultural competence on improving care for Maori. Alongside this remains the very important issue of improving care for our increasingly diverse multicultural population; diversity both in the origin of the doctors (as noted by the MCNZ, 41% of all practising doctors received their primary qualification from an overseas country) and of the patients. Wearn et al.,[1] in their survey of Auckland GPs, show that communication difficulties are a common feature of Auckland practice. From my perspective, caring for many patients with either no or limited English, a document on *'Cultural competence'* (the RNZCGP document) that makes no mention of the use of interpreters, has missed an important aspect of the skills needed for effective cross-cultural consultations.

Doctors in medicine are slow to react to some issues. Our nursing colleagues have been developing the issues around cross-cultural care for more than 10 years. The writings of Irihapeti Ramsden in relation to *'Cultural safety'*[2] were an important stimulus to this debate in nursing. The current Nursing Council clearly distinguishes two related but separate domains:

'Competency 1.2: Demonstrates the ability to apply the Treaty of Waitangi/Te Tiriti oWaitangi to nursing practice

Competency 1.5: Practices nursing in a manner that the client determines as being culturally safe'[3]

I believe that the Treaty of Waitangi is an important document and provides the principal negotiating basis for the relationship between Maori and the Crown. Maori are the indigenous people of New Zealand and, as the Treaty partner, the Crown is responsible for ensuring that health services are accessible and acceptable to Maori.

While current literature[4] addresses cultural responsiveness to Maori, other cultural groups are not as well served. A bicultural rather than a multicultural response is also reflected in the Medical Council document, *'Cultural competence standards'*: *'14(g). An awareness of the general beliefs, values, behaviours and health practices of particular cultural groups most often encountered by the practitioner.'*

Ramsden is critical of this approach to cross-cultural care:

'Ethno nursing as used within the Transcultural Nursing programmes

has developed from cultural anthropology and takes on an observational approach to other cultures. While care remains focussed on the "cultural" activities of the patient, there remains the tendency to promote a stereotypical view of culture over time thus making it difficult to respond to individual diversity. This can lead to a static approach to culture where groups of people come to hold an unchanging and uniform set of beliefs:

The problem of stereotyping cultures is compounded by the assumption that the country of origin of a person (or his/her parents) identifies the most significant dimension of his/her experience.

Cultural knowledge belongs to the culture and as such, cultural identity and traditions should remain with the culture. Teaching nurses to be experts in Maori culture leads to further disempowerment of Maori, given that there are significant numbers who have been deprived of knowledge of their own identity and traditions. Ethnographic information is only one facet of many Maori health issues, albeit very significant. The question could be asked, how does Transcultural Nursing theory educate nurses to give service to culturally dislocated adolescents with perhaps a serious self destructive urge? This age group comprises a significant percentage of the current Maori population who are highly at risk of self-harming behaviours and suicide. Cultural Safety is based in attitude change. If nurse and midwife practitioners hold safe attitudes, they will be able to work with the continuum of Maori people, from traditional practitioners of the culture to those who have been denied any information about Maoritanga."[2]

I suggest that the RNZCGP *'Cultural competency'* document, while including many concepts from *'Cultural safety'*, is also partial in its responsiveness to groups other than Maori.

The following is an approach that I have developed in my own clinical practice where I am regularly in contact with many different ethnicities with their own cultures and many with their own language.

The model of learning about the culture of my patients, promoted in the Jansen and Sorrensen article,[4] has prompted me to articulate a model that is helpful in culturally diverse practice. In my day-to-day work I see people from many cultures: Maori, Pakeha, Pacific Peoples, Assyrian Christians from Iraq, Somali Muslims, Ethiopians, Cambodians, Vietnamese and small numbers from many other places. It is possible with some effort to learn to pronounce names properly and to pick up greetings in the main languages, but I will never have a detailed understanding of all of these cultures. In addition, we also care for a number of other groups who traditionally do not have good access to primary care; people with addictions, people with enduring mental illness, people who live on the streets. They also have a set of values and beliefs markedly different from mine.

The ideal is for people to receive care from people of their own culture. For many, this is unlikely to happen in the medium term. The next best option is for people to receive care from a carer who has a deep understanding of their cultural background. Doing this without being fluent in the language of that culture is very difficult and, in New Zealand, where the majority of citizens only speak one language (English), learning a second (or third or fourth) language is a considerable barrier.

There is, however, much we can learn to provide care for those whose cultural background is significantly different from our own.

This is what I have learned.

What is 'culture'?

My *Oxford Dictionary* provides many definitions of this word but two are apposite:

'The customs, arts, social institutions and achievements of a particular nation, people or other social group';

'The attitudes and behaviour characteristic of a particular social group.'

Is 'culture' the same as 'ethnicity'?

For many people these two concepts are congruent. The vast majority of ethnic Samoans living in Samoa adhere closely to Samoan cultural practice.

The problem is that there are increasing numbers of people for whom ethnicity is not an accurate predictor of their cultural behaviour for two main reasons:

- They are living or were born in a society away from their ethnic home
- They are of mixed ethnicity.

There are many ethnically Samoan people who were born in New Zealand. How culturally Samoan they are depends on many factors: whether they speak the language, how many generations since they lived in Samoa, whether there is a community of Samoans nearby or whether they are isolated from other Samoans. In short it is a matter of to what extent they are assimilated into the mainstream culture. People of mixed ethnicity may define their ethnicity in different ways according to circumstances. My mother was born an American. I am eligible for an American passport. I consider myself a New Zealander. Part of my cultural background is American but, for the most part, I do not think of it as being very significant; however, for the purposes of ease of travel to the US I am able to be an American, travelling on an American passport.

Until 1986 the Government determined that a person was Maori if they had greater than 50% Maori blood. This was in considerable conflict with the Maori concept based on 'whakapapa', those who have descent from Maori.

The standard that we now use is: Ethnicity is the ethnic group or groups that people identify with or feel they belong to. Ethnicity is a matter of cultural affiliation, as opposed to race, ancestry, nationality

or citizenship. Ethnicity is self perceived and people can belong to more than one ethnic group.

The census question is now *'Which Ethnic Group do you belong to?'* with multiple answers possible.[5]

Knowing which cultural group(s) a person belongs to means that some predictions can be made regarding the beliefs of that person. On a population basis this can be essential for planning. For example, most Somalis are Muslim, therefore if we have a lot of Somali migrants there will be a need for separate places of worship from the Christian population. On an individual basis, knowledge of a person's origin is helpful but not infallible. Not all Somalis are Muslim and the degree of devotion to their religion varies, so if you manage your Somali patients on the assumption that they are all Muslim you will be right most of the time but may cause offence to the few who are not.

Mason Durie[6] has written about Maori reality and broadly divided Maori into three groups:

1. Maori who actively participate within Maori cultural institutions, who feel uncomfortable participating in the 'mainstream' of Pakeha New Zealand.
2. Maori who actively participate within Maori cultural institutions, who are comfortable participating in the 'mainstream' of Pakeha New Zealand.
3. Maori who are alienated from their Maori culture and also feel uncomfortable participating in the 'mainstream' of Pakeha New Zealand.

As a generalisation, those in the second group have access to appropriate care. Those in the first group will benefit from *culturally competent care* as described a in the section of Jansen and Sorrensen's paper *'Maori views of cultural competence'*, but the third group may be further alienated if they are treated with the expectation that they behave culturally as Maori. While I agree that it is important to document ethnicity, as for many it will give a guide to culture, it is not sufficient to ensure good care because of the inevitable assumptions that are involved.

What other 'cultures' are there?

There are many characteristics of a person, other than ethnicity, that contribute to their values, beliefs and practices. The obvious ones are religious belief, sexual orientation and level of education. Less obvious, but important, are things such as whether they share the 'Western Medical' view of how bodies work. Age can be an important determinant; those who lived through the Depression have a different view on throwing things away (hence the cupboards full of old medicines?). Most doctors do not have a great deal of knowledge of the 'criminal' culture. I have found it challenging caring for a now released convicted murderer. As a parent I have learned a number of lessons that I could not have learned any other way, enabling me to 'share' a culture with other parents, which I could not do before I had children.

In brief there would be no person that you could summarise all their views on the world by knowing their 'culture'.

Principles of good cross-cultural care

1. Respect

This may seem obvious but it is the cornerstone of good cross-cultural care. If you are unable to respect your patient and their values and accept that they may be different from yours, then you will not be able to care well for people with significantly different values from you. This sounds a bit sanctimonious; of course we all respect our patients' values don't we? I think my meaning is clearest if we look at it through an extreme example.

Many of the Somali women we care for have been genitally mutilated. I personally find this practice abhorrent and abusive. I wish I could just stop them doing it. It has in fact been made an illegal practice in New Zealand. Nonetheless, this is a deeply embedded cultural practice. There is a difference between respecting and agreeing. I disagree with this practice, but if I am unable to respect their position I will not be of much use. The only people able to change this practice permanently are the Somalis themselves, if they choose to do so. After the law banning genital mutilation was passed, some funding was set aside for 'education' of those who traditionally practised this. Our service applied for that funding. We consulted with the community leaders and offered to run a series of educational evenings on health topics that they were interested in. They talked about nutrition in New Zealand, common childhood illnesses, childbirth and gynaecological problems. Inevitably, as a part of this, the effect of genital mutilation was discussed, with their job to present as clearly as possible what is known about the medical consequences. These evenings were very successful with a larger attendance than expected and a lot of positive feedback. Had we been in any way disrespectful no one would have attended.

2. Know your own culture

This may sound simplistic, but in the context of cross-cultural care it is about understanding your base assumptions. For example, doctors trained in New Zealand all have a shared, detailed understanding of how the human body works. Everyone in the world does not share this understanding. For example if your patient believes in homeopathy and you do not uncover this difference, then there are likely to be conflicts regarding the taking of allopathic medicine. An important element of knowing your own culture is to know what 'stereotypes' you hold (e.g. all 'junkies' are liars.) This is not to say that stereotypes are not useful (many 'junkies' are liars), but if you are not aware of your own prejudices (pre-judgings) then you

are likely to provide poor care for some patients.

3. Be non-judgmental

It is simple to be non-judgmental in a consultation with a patient whose values are congruent with your own. The further those values diverge from your own, the harder it gets. The reality is that there are many people you will consult with who hold views and beliefs that are different from yours. One way of addressing this is to explicitly state your own views or beliefs and ask them for theirs; *'in my culture we believe that...what do you believe in your culture?'* One of the difficulties with this is that merely avoiding the subject of conflict can be interpreted as judgmental by a patient. Take the case of a woman who comes in and has a positive pregnancy test and bursts into tears, saying she does not want to be pregnant. If you make no mention of abortion as an option for her (particularly if your appearance fits the patient's stereotype of the sort of person who is opposed to abortion) she will probably feel some discomfort raising the topic. If, for example, you are opposed to abortion then you need to raise the topic and inform the patient of what you do for patients requesting an abortion if that is what she wants. Situations in which this is most important are those where sections of the community are quick to judge: sexual orientation, criminal record, illicit drug use, working as a sex worker.

There is a considerable art behind asking the 'naïve' question on sensitive subjects in such a way as to not offend. Prefacing the question with information on why it is important to know is helpful. For example, when asking a man who presents with an STD about whether he has sex with men; first explaining that in New Zealand HIV is more common in men who have sex with men can make the question less likely to cause offence to a patient who is homophobic.

4. Avoid the phrase 'non-compliant'

This phrase needs to be deleted from your vocabulary. What it means is that the patient is not doing what the doctor told them to do. The clear implication is that the doctor is right and the patient is wrong. This is anathema to good patient-centred medicine. It is, however, a very useful 'red flag'. Any patient who has ever been labelled 'non-compliant' has some important unresolved issue. It may be as straightforward as ambivalence about taking medication because of an even balance between benefits and side effects, or it may be an indicator of a major cultural clash requiring skilful consulting to determine where the clash is. Non-adherent is better, but the phrase that I prefer is that there is a mismatch between the doctor's and the patient's agendas. This serves as a reminder that it may be that the doctor rather than the patient is 'wrong' and avoids judgement.

5. Beware of assumptions

I like to think of the issue of cross-cultural consultation as a continuum from one extreme where all relevant values and beliefs are congruent between carer and patient, to the other extreme where all relevant values and beliefs are dissonant or conflicting. We all make assumptions all the time. As long as they are the same assumptions our patients make then all will be well, but if they are not then problems will arise.

A good example is the question used to find out whether someone is sexually active. Possible questions are:

- 'Are you married?'
- 'Do you have a partner?'
- 'Do you have a girlfriend (boyfriend, if talking to a woman)?'
- 'Do you have a girlfriend or a boyfriend?'
- 'When did you last have sex?'

There are assumptions behind all of these questions that could backfire and, if asked bluntly, all have the potential to offend someone. The usual circumstances in which sexual activity is relevant is when the doctor is assessing the likelihood of pregnancy and the likelihood of sexually transmitted disease. I once admitted a woman to hospital to exclude ectopic pregnancy (late at night after a home visit). I had asked whether she was sexually active and she answered yes. As I drove her to the hospital with her 'flatmate' (a woman) in the car it dawned on me that she was almost certainly a lesbian.

If knowing about sexual activity is important, then a proper assessment cannot be done without the detail of who did what to whom and when. As Bill Clinton has shown, 'having sex' can mean different things to different people.

More difficult are circumstances when you are unaware of the patient's assumptions. I have had several Somali mothers ringing me for after hours care of their babies because of vomiting and diarrhoea. They invariably have said that the baby had not drunk for days and was very very sick. I would arrive and find a child who did not seem very ill and felt frustrated at being called out urgently when I did not think it was necessary. After discussion I understood that many babies died in the refugee camps of this sort of illness and the extent of the mother's concerns was a reflection of this.

A common assumption of doctors is to presume that physical symptoms are caused by physical illness (until proved otherwise) A colleague had a case of an Ethiopian man who had abdominal pain. The cause of this was eventually diagnosed as due to a curse put on him by a neighbour in Ethiopia, but only after he had had multiple blood tests, two gastroscopes, a colonoscopy and abdominal CT. He was 'cured' with paroxetine and holy water.

6. Use interpreters carefully

This is a difficult area because there is little or no funding for professional interpreters to work in primary care.

The ideal for consulting with a person who is not a confident/comfortable English speaker is to use a professional interpreter. Using family members or friends is often better than nothing, but there are significant dangers:

- You do not know what the quality of the interpreting is like
- The issue of confidentiality is difficult, often it is impossible to ask sensitive questions using a family member interpreter
- Using children to interpret for parents creates difficulties for the child–parent relationship
- There is a much greater risk of the interpreter speaking for them, rather than interpreting.

A good interpreter can also act as a cultural broker, warning the carer when the questions they are asking might cause offence in their culture and why.

Useful tips for improving a consultation that uses an interpreter are:

- Remember that you are consulting with your patient, not the interpreter
- Face the patient and address questions to the patient in the first person – *'where do you get the pain?'*
- Look for body language cues and listen for 'anglicised' words that may be used, as this gives a small opportunity to judge the accuracy of interpretation
- Arrange seating in an equilateral triangle so that you and the patient can easily relate with each other and the interpreter
- Keep your sentences short
- If you sense that direct interpreting is not happening, try to slow the consultation down to very short sentences, explicitly asking for interpretation after each sentence (I will often use hand movements from the interpreter to the patient to signify this) and pay particular attention to addressing the questions directly to the patient
- Not all concepts will be easily translated. We know what bipolar disease is, but this is not a described concept in Somali.

7. Do a Well Health Check

The regular consultation has an unwritten agenda that the purpose is to respond to the patient's concerns. In that context it is sometimes difficult to raise important, but to you relevant, issues without risking offence.

At our service all new patients are booked for an appointment with a nurse for a Well Health Check as soon as possible after they register with us. This enables us to gather all the usual past medical history, allergies, medicines and so on. We describe the nature of the service we provide and what they can expect from us. We then go on to find out about ethnicity, language and relevant cultural practice. We ask questions about who is at home with them, whether they have a partner, whether there are any issues with family violence, gambling, use of addictive drugs. We couch all of this in terms of 'in order to care for you we need to understand who you are'. It is then much easier to ask many questions that in other circumstances are harder to ask, on the basis that we ask this of all our clients because for some of them they are important.

8. Learn to pronounce names

I get annoyed when people spell my name GREY rather than GRAY. It is an incredibly small thing, but nonetheless that is how I feel. It is my experience that addressing people by the correct name properly pronounced makes a big difference to the tone of the consultation, especially for people who are used to most New Zealanders mispronouncing their names.

More generic issues

1. Practice patient-centred medicine

The book entitled *'Patient-centred Medicine'* by Moira Stewart et al.[7] describes six features that they see as the elements of patient-centred medicine:

1. Exploring both the disease and the illness experience
2. Understanding the whole person
3. Finding common ground
4. Incorporating prevention and health promotion
5. Enhancing the patient–doctor relationship
6. Being realistic.

The book does not explicitly address the question of cross-cultural consultation. It is written to describe a 'new' way of looking at the consultation rather than the old 'doctor-centred medicine'.

Everything that I have written above is a logical consequence of pursuing this way of consulting.

It provides the philosophical framework within which I work.

2. Supervision

Practising good patient-centred medicine requires all of these things but, in particular, to be good at it you need self-awareness. If particular patients annoy you, then you will be unable to care for them well unless you understand where that annoyance comes from. I have found an invaluable aid to achieving better patient-centredness has been attending 'Supervision'. This is a concept from the counselling and social work disciplines. It involves seeing a trained supervisor (usually someone with a counselling background of some sort) to discuss things that are difficult in your work. This does not include 'clinical supervision' such as discussing the detail of pharmaceutical choices. Nor does it include extended personal psychotherapy. It is something in between. I have found it particularly useful:

- Following the death of a baby of meningitis nine hours after I had diagnosed a viral infection.
- Dealing with friction between myself and work colleagues.
- Monitoring my mood during a particularly stressful family time to ensure I was not too stressed to practice safely.

- Discussing 'boundary issues', for example, times when I have or have not used a chaperone.

It has been immensely useful for me to be aware that, similar to many doctors, I have a need to be liked and that I am scared of not knowing enough. Discussing 'heartsink' patients has enabled me to stop taking responsibility for problems that are not mine and to be more effective with what I do.

3. Practising community-centred medicine

Providing care for diverse cultures is easier if those cultural groups have input in to how the care is provided. There are things to be learnt about how a cultural group behaves that affect how a service is offered. For the more vulnerable groups in our community, health is affected by many more things than narrowly focused health services. To be effective, health providers need to participate in a community development model that includes attention to housing, childcare, rehabilitation services, English language classes and many other things.

4. Learning about the cultures of your patients

Of course it is useful to know as much as you can about the culture of the patients in your practice. Understanding the detail of how people fast during Ramadan (and what variation there is in adherence) is of course useful in caring for Muslim patients. The main point I am making is that knowledge of generalisations about other cultures without an understanding of *cultural safety* as described by Ramsden[2] and interpreted as I have described above, could make your cross-cultural consultations worse.

Enjoy the journey and the dance

When I left medical school I was well inculcated with the view that the job of a doctor was to take a history, examine, order investigations, make a diagnosis, treat and cure the patient. I felt a responsibility for my patients' problems and if things went badly (some of them even died) then I took this personally.

I have gradually shifted the sense of my job and now see that I am accompanying my patients on their journeys. They have many problems, some I can influence, some I cannot. I try to understand how they see their problems and apply all the skill I can to see if I can help them find the best road for their journey. Sometimes I make a huge difference (e.g. the drowning toddler that I resuscitated) sometimes I can only provide comfort. Like all humans I make mistakes and I try to learn from them. All of my patients will die.

Providing care for diverse cultures is easier if those cultural groups have input in to how the care is provided

It is like a dance, sometimes close, sometimes apart, sometimes synchronised, sometimes stepping on each other's toes. They choose whether they want to dance with me. If I am too awful they will find someone else to dance with. If they are from a strange land there may be no one who knows their dance. If they choose me to dance with then we both have to learn each other's steps and hopefully find a beat we can both dance to.

Cultural safety or cultural competence?

By not separating out *cultural safety* and Treaty of Waitangi issues the Medical Council has created the possibility that a doctor could be *culturally competent*, but not meet the standards in *Best practice in the care of Maori patients* (if, for example, they had few Maori patients). I think the separation that the Nursing Council suggests works much better and is more explicit about achieving both goals rather than the Treaty of Waitangi goals being under the guise of '*cultural competence*'. *Cultural competence* also sounds like something you reach, whereas *cultural safety* is something you continue to work on. I think this sits better. In any clinical setting there is a continuum from '*culturally identical*' to '*culturally completely different*.' The competence of all of us in any particular setting will vary. A less culturally competent practitioner may well be fine if they work closer to the 'culturally identical' end of the spectrum, whereas the most culturally competent practitioner may still provide poor care at the 'culturally completely different' end of the spectrum. In either instance they can only do their best. The other vital difference between the concepts is that, from the Medical Council's document, this competence can be judged by other clinicians. Ramsden and later the Nursing Council both make it very clear that whether a consultation was culturally safe is judged by the patient.[8] This makes 'assessment' of whether the standard has been met more complex but in my view more real.

Conclusion

The increased focus on cross-cultural care is welcome and needed. Our profession has started to produce material to inform practitioners on this subject. One of the most important 'cross-cultural' issues is about Maori patients being seen by non-Maori practitioners and this has been an important driving force behind the development of materials. I believe that this has led to a slightly confused approach to this issue. The nurses base their approach on the Treaty of Waitangi and *cultural safety* and I believe that there is significant benefit in approaching these issues in this way compared with the current view of the Medical Council and Colleges.

Competing interests

None declared.

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In response

Dr Ben Gray has provided his views of the guidance produced by the Medical Council of New Zealand in the area of cultural competence. The resource booklet *Best health outcomes for Maori: Practice implications* released in October 2006, complements the two Medical Council statements about cultural competence and health outcomes for Maori, released in August 2006, and all these are available from the MCNZ website http://www.mcnz.org.nz/Publications/tabid/62/Default.aspx .

Both the Medical Council and the RNZCGP guidance were developed because of the requirements of the Health Practitioners Competence Assurance Act 2003. Section 118(i) of the HPCA requires all health practitioner registration bodies (including the MCNZ) to *set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners*.

Understandably the MCNZ and most health practitioner registration authorities use that terminology rather than the terms *cultural safety*, *cultural sensitivity* or *cultural awareness*. The terms *cultural competence* and *clinical competence* appear together, highlighting the need to address cultural, communications and technical abilities to ensure public safety.

The MCNZ and the RNZCGP have gone further by developing guidance or standards that specifically address Maori issues. This is reasonable given the context of practice is Aotearoa/New Zealand where Maori have been shown to have the greatest health inequities. No doubt additional guidance relating to Pacific peoples, migrant populations and others will follow.

These professional standards complement the requirements of the Code of Health and Disability Services Consumers' Rights. The Right to Effective Communication (Right 5) includes: *'Where necessary and reasonably practicable, this includes the right to a competent interpreter'.*

Together the HDC Code, the MCNZ and the RNZCGP documents provide a framework for addressing cultural competence within the general practitioner workforce.

We note that for the most part Gray is in agreement with the approach of the MCNZ and RNZCGP. Neither body advocates a one-dimensional approach to culture and ethnicity in keeping with the plain fact that most people have many cultural affiliations even if they identify with only one ethnic group. More than that, doctors need to be aware of smoking history, family connections, medical history and a myriad of matters which can impact on patient responses to the recommended treatment. Doctors should also consider that patient preferences will vary over time and in response to things like the stage of illness.

The documents from the MCNZ and the RNZCGP address these matters, and advise doctors to take care to avoid generalising, making assumptions or failing to check the understanding of patients and their families.

We do not agree with Dr Gray in a number of areas. Firstly, we would see the ideal as being for any health provider to have the knowledge, skills and attitudes to engage with any patient. Of course some patients may have a preference for a provider of a particular gender or ethnic group at times.

Secondly, we abhor the practice of genital mutilation. Like other abandoned practices this has no place in any society. We suspect that Gray is advocating a respectful approach towards people rather than respect for all points of view, however objectionable. This is important because respect and trust are the foundation of all good doctor–patient relationships that then allows us to discuss practices that harm the health of patients such as smoking or even genital mutilation.

Lastly, we note that the MCNZ statements and the HDC Code are not optional matters. Doctors cannot choose to adhere to the statement about health outcomes for Maori while ignoring the statement about cultural competence. Like Gray, we urge doctors to learn more about the backgrounds of patients they see. We also urge doctors to consider carefully how they will implement the MCNZ and RNZCGP guidance into everyday practice.

Dr Peter Jansen FRNZCGP,
on behalf of Mauri Ora Associates
www.mauriora.co.nz