Reflecting on cultural competency

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The RNZCGP formally launched the *Cultural competency guidelines for general practitioners* at its recent conference. I was humbled by the privilege to stand on the podium as the Chair of Te Akoranga a Maui (Maori Faculty) with the President of the College, Dr Jonathan Fox, to announce the launching of this important document.

The guidelines were developed over a lengthy period of time after consultation with general practitioners and the wider community. This document reflects the current legislative requirements with respect to general practitioner and patient engagement. My challenge to our colleagues is to embrace and critically review it and contribute to its continuing improvement. As the landscape of our health system constantly changes, so does the cultural diversity of both our patient population and our health workforce.

At the conference dinner I was sitting next to a colleague who regarded her/himself as an 'heretic', having abandoned the Cornerstone practice accreditation programme for several reasons, the one most strongly felt being around the specific Maori Health Policy that practices are required to have developed/adopted for this process. My initial reaction was one of anger – this person must be a redneck (I am GP of Maori and Scottish descent), followed by defence, trying to justify the specific Indicator (I am a Cornerstone Assessor). However, as the night grew it became clear to me that this person was not a redneck, nor someone who scoffs at the importance of quality in our practice. As a sideline this person also runs a highly technical manufacturing plant for the export market. Without a robust culture of quality this could not compete on the international market. This colleague has been working in general practice for many years, employing other doctors and caring for over 4000 patients under a high access agreement with the local PHO. S/he feels that they have always treated their patients (including a high proportion of Maori, Indian and Pacific people) with equal respect and care. S/he feels 'pissed off' because their local Maori health provider appears to be getting significant resources and doing very little – minimum doctor time, no after hours care etc. S/he also notes the significant high needs that many of their non-Maori patients have and is struggling with the notion of 'special treatment' for one ethnic group.

I was pleased and impressed to see that s/he attended the Cultural Competency workshop the following morning. I hope that her/his concerns/frustrations were appropriately addressed. I was even more impressed with the high number of attendees at this workshop.

Reflecting on this experience, and from other observations throughout the country, I sense that s/he is not alone. The removal of the designated scholarships for Maori and Pacific GP registrars is a testimony to the changing political environment.

Unfortunately we do get confused with all the political agendas of different groups – general practitioners included. What is not confusing, however, is the overall intent of each and every one of us to do the best that we can.

As the *Cultural competency* document is launched, I urge you, my colleagues, to use this as a framework, to regard this as a living document – not as a protocol.

It is important that we acknowledge and celebrate our ethnic cultural differences. However, once we have done that, we should turn our focus on what we have in common – our humanity. It is only by focusing on what we have in common that we can move forward.

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It is appropriate that at this point I introduce a new concept. The concept of Maoriness. This concept is similar to that of Kiwiana. All Kiwis, irrespective of their whakapapa (genealogy), have a degree of Maoriness. A simple test would be to observe one's reaction (heart rate/goosebumps) when standing in Piccadilly Circus in London or Times Square in New York and hearing the All Black Haka, or *Pokarekare Ana*. If you react to either of these you are a true Kiwi; this is your Maoriness. As Kiwis we all identify with New Zealand, with our flora and fauna, with our skies and mountains, with our glaciers and volcanoes, with our rivers and lakes. All these are intrinsically connected to one people – Maori. We all proudly carry a Maoriness; therefore, without Maori, there is no New Zealand – otherwise we could be anywhere in the world. We, as Kiwis, take pride in who we are, the place we stand on, the space we occupy on this planet. As Kiwis we have a right and an obligation to protect our Maoriness. By looking after our Maoriness, we are, in fact, looking after ourselves. This is true equality.

Our Maoriness is expressed through our values such as manaakitanga (supporting, nurturing), kotahitanga (unity, trust), or rangatiratanga (honesty, respect, personal mana), whanaungatanga (family connections). Our own College is a clear reflection of tino rangatiratanga (self-determination); we as GPs, and we alone, strive to determine our own future. This notion is not about 'assimilation' or 'one nation one people', it is about our uniqueness as Kiwis, it is what separates us from the rest of the world. So let us celebrate our differences and rejoice our commonness – our Maoriness.

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Over the last 17 months I have been privileged to visit over 100 practices and meet several hundred staff (I am also a GPEP2 Assessor). Despite what the gloom brigade has to say, general practice in New Zealand is alive and well. What I am greatly moved by is the overwhelming dedication, commitment and passion at the practice level. Yes, I have come across some disheartened, grumpy colleagues, but as in all walks of life, there are such people and they are mostly unhappy with life in general rather than specifically with general practice. The resurgence of teaching and research and the move towards creating environments of learning is injecting a new buzz into general practice.

Returning to my enjoyable dinner and interesting company, I was once again reminded of the most important feature of our College conferences – the fellowship. The opportunity to inspire and be inspired by each other, irrespective of our personal belief systems. What a boring world we would have to live in, if we all were the same.

Competing interests

None declared.

When a patient dies

'In recent years, other physicians have told me about the rituals they perform when a patient dies - offering a prayer, a poem, a gesture - something that each has felt compelled to do to recognize the life lost and the fact that, in the final analysis, death will always win. What is striking is that most of us do this in private. We don't share these rituals. We don't talk easily about how hard it is to lose a patient, to confront death. In the anatomy laboratory, we learned to focus on the path of the vagus nerve, not the human being to whom it belonged. Early in our training, bending over our cadavers, we learned to silence a part of ourselves. We learned the power of humor as a means of avoiding hard conversations about more complicated feelings. Often we kept those feelings to ourselves, rarely giving voice to them as we proceeded through far more challenging situations during our clerkships - a newly diagnosed lung cancer, a 2-year-old with an inoperable and therefore fatal brain tumor, a young man with quadriplegia from diving into shallow water. We discussed the medical management and the complications in detail and with intense care, but we could not give voice to the feelings these events evoked, often reducing them, in the formal case presentation, to the single word "unfortunate".'

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