Developing cultural competency in accordance with the Health Practitioners Competence Assurance Act

Kira Bacal, Peter Jansen and Kathleena Smith

Correspondence to: kathleena@mauriora.co.nz

***Kira Bacal** is an American physician with medical specialties in Emergency Medicine and Aerospace Medicine, as well as a PhD in molecular physiology and a Masters in public health. In addition to serving as a consultant to Mauri Ora Associates, she is also a faculty member at Ohio University and the director of the Appalachian Rural Health Institute.*

***Peter Jansen** (Ngati Raukawa) has extensive experience as a GP, but now works as a teacher and researcher for Mauri Ora Associates, as well as part-time Medical Advisor to the Treatment Injury and Patient Safety Unit of ACC.*

***Kathleena Smith** (Ngati Raukawa, Ngati Ranginui) graduated from the University of Auckland in 2005 with Bachelors degrees in Law and Arts, majoring in Maori Studies. She has worked for ACC in the Treatment Injury and Patient Safety Unit (formerly Medical Misadventure), and is now a Project Co-ordinator for Mauri Ora Associates.*

ABSTRACT

The New Zealand health care system, like that of other countries from Europe to the Americas, does not provide equal health outcomes to all members of its population.[1-3] Poor health is disproportionately greater among those whose cultural background differs from the majority population.[4-7] Culture thus serves as a marker of special needs and, as such, awareness of culture is an important skill for a doctor to possess.

Introduction

Culture can influence expectations and perceptions of the health care system on the parts of both the patient and provider. It can also affect factors that play a role in effective communication, such as body language, comfort with expressing disagreement, modesty traditions, and disease attribution (i.e. beliefs regarding the nature and causality of wellness, disease, and injury).

What is cultural competence?

Although some mistakenly assume that 'culture' means 'race' or 'ethnicity', people may be members of many cultures simultaneously, based on gender, religion, age, occupation, geographic location, leisure activities, social class, sexual orientation, or many other characteristics.[8] For example, a 44-year-old person may simultaneously be a member of numerous groups, such as men, Maori, rugby players, bankers, sailors, world travellers, fathers, and gourmet cooks. This individual may alter his speech patterns, conversational topics, body language, and behaviours based upon which cultural group he is engaged with at any given time. Similarly, his doctor should take all these different aspects of his life into account when discussing his health and considering diagnostic and therapeutic options.

Particularly in the case of family practice, clinical care is founded upon effective communication, yet communication relies heavily upon cultural referents and practices. Thus the need to understand the cultural context of the patient within their community, as well as their views of illness. According to Professor Mason Durie, *'Cultural competence is about the acquisition of skills to achieve a better understanding of members of other cultures'* so that the patient/doctor relationship is as close and productive as possible and the best possible clinical outcome can be achieved for the patient.[9]

Particularly in the case of family practice, clinical care is founded upon effective communication, yet communication relies heavily upon cultural referents and practices

Because cultures differ in body language, how to show (dis)respect, modesty and privacy concerns, expressions of (dis)agreement, and what constitutes courtesy, it is easy when dealing with someone from another culture to unwittingly give offence or to unintentionally make someone feel awkward, uncomfortable, or confused. In a medical setting, patients are often already uncertain, intimidated, and/or apprehensive, so anything that worsens, rather than improves, these feelings tends to create additional barriers between the doctor and patient.[10] Numerous studies, reviewed by Levinson, demonstrate that patient outcomes improve when patients' cultural, emotional, and personal concerns are considered along with their medical condition.[11]

Just as general communication skills can be learned, as when students are taught to take a medical history, so too can study improve cultural competence.[12-14] Evidence for this comes from work recently sponsored by the United States Agency for Healthcare Research and Quality (AHRQ),which reviewed a variety of strategies to improve both the cultural competence of health care providers and the quality of health care received by minority populations. After reviewing over 3500 papers (of which 91 were suitable for full evaluation), the authors of the study concluded that cultural competency training can improve the knowledge, attitudes, and skills of health care providers and that there is additional evidence that the training can also improve patient satisfaction and adherence to care.[15]

Neuwirth and Lockyear compare learning how to communicate with patients effectively to learning a musical instrument – some people may be more naturally gifted at it, but everyone can learn the basics, everyone can improve with effort, and everyone requires continual practice to maintain their skills.[12,16,17] This is why useful training in cultural competence cannot be accomplished in a 'one off' course but rather requires lifelong learning. A goal of the Health Practitioners Competence Assurance (HPCA) Act is to encourage clinicians to incorporate cultural competence skills into daily practice, making continuous adjustments as practices and patient populations change over time.

The more a doctor understands about a patient, the more likely he or she will be able to make the proper diagnosis and suggest an effective (and acceptable) course of treatment. *'How does one take care of patients without knowing the social and cultural contexts from which they come or without knowing the complex interplay of patients' values and beliefs with their conceptions of health and illness?'*[18] After all, the patient's understanding of their illness or injury influences their decision to seek care, as well as affecting their understanding (or acceptance) of the doctor's explanation for it and the associated treatment.[19] Nor do patients view their medical experiences as separate from the issues of their everyday lives.[11] As Levinson writes, *'patients expect physicians to go beyond merely attending to their biomedical needs...Many patients view their physicians [particularly their GPs] as individuals whom they can trust*

Case Study

JM, a 62-year-old Maori man, appears at the office of Dr B, a general practitioner. He explains that Dr B is his daughter's doctor and she encouraged Mr M to seek medical care for an injury to his leg. Dr B takes a few minutes to talk about Mr M's daughter and her family, as well as to ask about the rest of Mr M's family. Upon learning that several members of the family are in the waiting room, he asks Mr M if he would like them to be present. At Mr M's affirmative reply, the practice team take time to introduce themselves and get acquainted. Although this takes a few minutes, Mr M is now much more relaxed and talkative. He, with some comments from family members, describes the injury to his foot. His wife mentions that she is concerned that the injury has been very slow to heal and wonders if this is because Mr M has diabetes. Arrangements to see a specialist regarding the ulcer that has developed from the injury are made and in follow-up visits it is confirmed Mr M has diabetes. Dr B acknowledges the insight that Mrs M has and, in consultation with a Maori nurse educator, establishes a plan to assist Mr M and his whanau to learn more about diabetes and take control of his condition.

with their most intimate information – including the stresses of their daily lives and their personal worries.'[11] Patients were four times more likely to bring up psychological concerns, family problems, and life stresses to their primary care doctor than to a specialist (surgeon) – suggesting that it is particularly critical for GPs to be familiar with their patients' social and cultural milieu.[11]

Why do we need to develop cultural competency?

Research has shown that the persistent disparity in Maori health is due, at least in part, to behaviours on the part of their health care providers.[20,21] Maori receive fewer referrals, fewer diagnostic tests, and less effective treatment plans from their doctors than do non-Maori patients;[22] They are interviewed for less time by their doctors and are offered treatments at substantially decreased rates.[23-26] They are also prescribed fewer secondary services such as physiotherapy, chiropractors and rehabilitation. All this, despite the fact that compared to non-Maori, Maori are on average sicker, for longer periods, during their shorter* lives.[5,27,28]

Maori comprise at least 4.5% of every local authority within New Zealand, including 13.1% of Invercargill, 11.6% of Auckland, and 44.7% of the Far North District.[29] However, only 2.3% of active New Zealand medical practitioners are Maori,[30] and so most Maori patients will be seen by someone who does not share their cultural background. Despite the sizable Maori population in all regions, many doctors remain ignorant of Maori cultural practices and others hold inaccurate or inappropriate views. For example, in a 2002 study, McCreanor and Nairn found that despite being familiar with Maori-related health disparities, many non-Maori GPs *'either blame Maori for their plight or justify existing [inadequate] service provision.'*[31] Similarly, Johnstone and Read's anonymous survey of 247 New Zealand psychiatrists found that the majority of European New Zealand-born male psychiatrists with more than 10 years experience believe Maori are naturally inclined to psychiatric illness, despite the complete absence of any scientific evidence to that effect.[32] These attitudes likely underlie many provider-based inequalities, and visiting such a provider can hardly be a comfortable experience for Maori patients.

For reasons noted above, it is both logical and necessary that the HPCA direct special attention to the ways in which the health care system can become more effective in addressing the health of Maori and other special needs groups.

The HPCA

The HPCA came into effect on 18 September 2004, and covers all health professionals.

In a nutshell, it was enacted so that New Zealanders will know *'that whoever provides their health care is competent, registered and subject to some form of sound regulation.'*[33]

Research has shown that the persistent disparity in Maori health is due, at least in part, to behaviours on the part of their health care providers

The HPCA requires that professional registration bodies set standards of cultural competency, clinical competency and ethical standards and to ensure that practitioners meet those standards (Section 118). Since commencement of the Act, health practitioner registration bodies have begun development of standards of competence and processes regarding ongoing assurance of both clinical competence and cultural competence.

For example, the Medical Council of New Zealand (MCNZ) has developed a statement and explanatory booklet regarding cultural competence. The Council writes, in part, *'It is expected that improved integration of cultural and clinical com-*

Key Points

- Culture affects the provision of effective health services as well as health outcomes.
- Health disparities are particularly great among members of minority cultures, and there is evidence that provider behaviour is a significant contributing factor to these inequalities.
- Cultural competence training can assist providers to be more 'in tune' with their patients and overcome bias.
- Cultural competence training is effective in updating providers' knowledge, skills and attitudes. Training can improve the satisfaction of clients with services, reduce complaints, increase the acceptability of care and can improve adherence to care.
- Cultural competence training and organisational policies have been shown to reduce disparities in care.
- As with other quality improvement activities, cultural competence needs to be demonstrated through independent assessments of performance, comparison with established standards, and provision of feedback to organisations and workers.

* On average, non-Maori live eight to 10 years longer than Maori.[10]

petence should lead to better outcomes through improvements in communication, acceptability of treatment, adherence to treatment plans, and through measurements of doctor performance in delivery of services to Maori.'[34]

Specialist bodies such as the Royal New Zealand College of General Practitioners, have also begun work in the area of cultural competence of their members. As stated by the RNZCGP, *'Cultural competence skills will help you to develop strong relationships with your patients and their families, leading to greater accuracy in diagnosis and improved treatment plans when consulting with people of cultural backgrounds that are different to your own. Ultimately, the result is greater doctor and patient satisfaction, with better health outcomes.'*[35]

The Medical Laboratory Scientists Board and registration bodies in pharmacy, podiatry, physiotherapy, occupational therapy nursing and others are actively developing frameworks for inclusion of cultural competencies into the training and registration of their practitioners.

In addition, funding bodies have also moved to incorporate cultural competence into contractual requirements. This is seen in the requirement of PHOs to develop specific Maori Health Action plans to address inequalities within their enrolled populations.

These initial efforts will lead over time to measures of performance and will need to be supported by ongoing educational programmes for health professionals.

In other words, once appropriate standards are developed, registration authorities must ensure that providers perform in the appropriate manner. This was signalled in a series of articles published in the *New Zealand Family Physician* in 2004, by Ian St George, Medical Advisor to the New Zealand Medical Council.[36-41]

In particular there is a need to develop objective and independent assessment of performance against standards with accurate feedback to practitioners. This type of approach is needed because self-evaluation, which has historically been used to evaluate competency, has not proved to be effective. Research has repeatedly shown that we overestimate our ability to communicate effectively with patients, misinterpret what issues patients view as important, and generally misjudge our own abilities.[11,16,42,43] In addition, doctors are selective in applying learned skills and only do so with certain patients, without realising that they are doing this.[44]

In order to achieve the goal that all registrants are not only familiar with the concept of cultural competence but are also able to demonstrate it, teaching programmes and registration bodies must develop and support competency standards as the first step. Furthermore, any cultural competence teaching programmes will need to be designed so that it assists practitioners in the performance of their daily clinical work.

What will be the benefits of developing cultural competency?

Because culture has a broad influence on health through communication, attitudes, behaviours, practices and customs,[45] developing cultural competency will provide patients with better care, more comfort with the health care system, and better health outcomes. Recent work such as that by Lieu et al.[46] confirms that training in cultural competence, objective assessment of practitioner performance with regular feedback supported by organisational cultural competence policies does lessen disparities in clinical care.

Summary

Research shows that numerous disparities exist among different cultural communities in New Zealand, with the most dismal health status consistently noted among Maori. These overall disparities persist even after controlling for associated factors such as poverty and education, indicating that culture is an independent determinant of health status.[47] Research has documented that cultural misunderstanding and (unconscious) bias on the part of some clinicians are partially responsible for these disparities, so improved cultural competence should yield improved outcomes.[28, 47] By making patients more comfortable in the health care setting, clinicians will be better able to work with patients and, as appropriate, their families to obtain the best possible clinical outcomes.

Competing interests

All the authors are employed by Mauri Ora Associates . MOA has assisted a number of organisations to develop cultural competence resources including ACC, the Medical Council of New Zealand, the Royal New Zealand College of General Practitioners, DHBs and others.

Reference List

1. Ajwani, S and others. Decades of disparity: Ethnic mortality trends in New Zealand 1980–1999. Wellington: Ministry of Health and University of Otago; 2003.
2. Counties Manukau. Counties Manukau chronic care management plan (unpublished report); 2001.
3. Ministry of Health. Reducing inequalities in health. Ministry of Health; 2002.
4. Sporle A, Pearce N, Davis P. Social class mortality differences in Maori and non-Maori men aged 15–64 during the last two decades. N Z Med J 2002; 22; 115(1150):127-31.
5. Skegg D, McCredie MR. Comparison of cancer mortality and incidence in New Zealand and Australia. N Z Med J 2002; 115(1153):205-8.
6. Carr J, Robson B, Reid P, Purdie G, Workman P. Heart failure: ethnic disparities in morbidity and mortality in New Zealand. N Z Med J 2002; 115(1146):15–7.
7. Ellison-Loschmann L, Cheng S, Pearce N. Time trends and seasonal patterns of asthma deaths and hospitalisations among Maori and non-Maori. N Z Med J. 2002; 115(1146):6–9.
8. Nursing Council of New Zealand. Competencies for entry to

the Register of Comprehensive Nurses. Wellington: Nursing Council of New Zealand; 2002.
9. Durie M. Cultural competence and medical practice in New Zealand. Australian and New Zealand Boards and Council Conference; 2001.
10. McPherson K et al. Ethnicity, equity, and quality: lessons from New Zealand. BMJ 2003; 327:443–4.
11. Levinson W et al. A study of patient clues and physician responses in primary care and surgical settings. JAMA 2000; 284: 1021–7.
12. Neuwirth ZE. An essential understanding of physician-patient communication Part 2. J Med Pract Management 1999; 15: 68-72.
13. Smith RC et al. The effectiveness of intensive training for residents in interviewing. Ann Int Med 1998; 128:118–26.
14. Yedidia MJ et al. Effect of communications training on medical student performance. JAMA 2003; 290:1157–65.
15. Agency of Health Research and Quality (AHRQ). Strategies for improving minority health care quality: Evidence Report/Technology Assessment #90. Washington DC: US Agency of Health Research and Quality (AHRQ); 2004.
16. Lockyear P. Physician-patient communication: Enhancing skills to improve patient satisfaction. Medscape CME 2004.
17. Travaline JM, Ruchinskas R, D'Alonzo GE Jr. Patient-physician communication: why and how. J Am Osteopath Assoc. 2005; 105(1):13–8.
18. Wear D. Insurgent multiculturalism: Rethinking how and why we teach culture in medical education. Academic Medicine 2003; 78:549–54.
19. Lo HT, Fung KP. Culturally competent psychotherapy. Can J Psychiatry. 2003; 48(3):161-70.
20. Baxter J. Barriers to health care for Maori with known diabetes. NZ National Working Group on Diabetes and Te Roopu Rangahau Hauora a Ngai Tahu; 2002.
21. Crengle S. The development of Maori primary care services. Pac Health Dialog 2000; 7:48–53.
22. Gribben B. Ethnicity and resource use in general practice in West Auckland. Experience in Practice TM. Healthcare Review – Online March 1999; 1(1). http//www.enigma.co.nz/eip_articles/9903. vol1no1_001.htm.
23. Ministry of Health. Maori providers: Primary health care delivered by doctors and nurses: The National Primary Medical Care Survey (NatMedCa): 2001/02 Report 3. Wellington: Ministry of Health; 2004.
24. Crengle S, Lay-Yee R Davis P Pearson J. A Comparison of Maori and non-Maori patient visits to doctors, NatMedCaReport 6. 2002.
25. Arroll B, Goodyear-Smith F, Lloyd T. Depression in patients in an Auckland general practice. N Z Med J 2002 Apr 26; 115(1152):176-9.
26. Westbrooke I, Baxter J, Hogan J. Are Maori under-served for cardiac interventions? N Z Med J 2001; 114(1143):484-7.
27. Reid P et al. Disparities in health: common myths and uncommon truths. Pacific Health Dialog 2000; 7:38–47.
28. Scott K, Marwick J, Crampton P. Utilization of general practitioner services in New Zealand and its relationship with income, ethnicity and government subsidy. Health Services Management Research, 2003; 16(1): 45-55.
29. ACC (Te Kaporeihana Awhina Hunga Whara). Summary guidelines on Maori cultural competencies for providers. Wellington: ACC; 2004.
30. Ministry of Health. New Zealand Medical Practitioners 2000. Wellington: New Zealand Health Information Service; 2001.
31. McCreanor T, Nairn R. Tauiwi general practitioners talk about Maori health: interpretative repertoires. N Z Med J 2002; 115(1167) http://www.nzma.org.nz/journal/115-1167/272/
32. Johnstone K&RJ. Psychiatrists' recommendations for improving bicultural training and Maori mental health services: a New Zealand survey. Australian and New Zealand Journal of Psychiatry 2000; 34:135–45.
33. Ministry of Health. HPCA Update. 2004:1, Ministry of Health.
34. Medical Council of New Zealand. Best health outcomes for Maori: Practice implications. In press 2006. Wellington: Medical Council of New Zealand.
35. Royal New Zealand College of General Practitioners. Culturally competent general practice in New Zealand. In press 2006. Wellington: Royal New Zealand College of General Practitioners.
36. St George I. Assessing performance 1: There but for the Grace of God go I. NZFP 2004; 31:45–47.
37. St George I. Assessing performance 2: How should the underperforming doctor be identified. NZFP 2004; 31:112-114.
38. St George I. Assessing performance 3: How well can peers and patients rate a doctor's performance? NZFP 2004; 31:189–192.
39. St George I. Assessing performance 4: Reviewing communication skills. NZFP 2004; 31:264–266.
40. St George I. Assessing performance 5: Assessing knowledge. NZFP 2004; 31:337–338.
41. St George I. Assessing performance 6: Reviewing proceduralists. NZFP 2004; 31:413–415.
42. Bull SA et al. Discontinuation of use and switching of antidepressants: influence of patient-physician communication. JAMA 2002; 288: 1403-9.
43. Zoppi K . Is communication a skill? Communication behaviors and being in relation. Fam Med 2003; 34: 319-24.
44. Edwards et al. Shared decision making and risk communication in practice. Br J Gen Pract 2005; 55: 6-13.
45. Betancourt J, Green A, Carrillo E. Cultural competence in health care: Emerging frameworks and practical approaches. The Commonwealth Fund. October 2002.
46. Lieu TA et al. Cultural competence policies and other predictors of asthma care quality for Medicaid-insured children. Pediatrics 2004; 114: 102-10.
47. Medical Council of New Zealand. Statement on best practices when providing care to Maori patients and their whanau. In press 2006. Wellington: Medical Council of New Zealand.