Pacific health perspective on social responsibility

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The theme of this issue of the New Zealand Medical Student Journal is “social responsibility”. When applied to health, this presents a value-based framework and proposes that an individual has an obligation to act for the benefit of society. With this in mind, I would argue that when it comes to health equity for Pacific peoples in Aotearoa, New Zealand (NZ), we are failing in our social responsibility.

Pacific health data can be difficult to find. One of the reasons for this is that equity measures often group Māori and Pacific data together, or simply present comparisons between Māori and non-Māori. The partnership between the Crown and Māori embodied in Te Tiriti o Waitangi demands an effective health system for Māori. Pacific peoples recognise their obligations, along with all peoples of NZ, to Māori. Unfortunately, these inequities in the system impact other groups in society, particularly Pacific people.

Understanding the demography of the Pacific population in NZ, and the socioeconomic factors impacting on Pacific peoples’ health, is important. The 2018 Census recorded over 380,000 people in NZ (8.1% of the total population) who identify with at least one Pacific group. This is projected to grow over half a million people by the year 2038. The term “Pacific peoples” is a collective term describing a dynamic and diverse population made up of more than 16 distinct ethnic groups, languages, and cultures. The Pacific population is youthful and becoming increasingly diverse. The median age among Pacific peoples is 24 years, which is 14 years below the median age for the general population, and only 5% are older than 65 years (compared to 14% of the non-Pacific population). The majority of Pacific peoples living in NZ today (59.3%) were born here.

Despite this growing diversity, a number of enduring cultural values are shared among Pacific groups, including:

- The central place of family (which contributes to identity and feelings of belonging)
- Collectivism and communitarianism (everyone working together to achieve common goals)
- The importance of spirituality (attributing life events to a higher power)
- Reciprocity (mutual help and interdependence)
- Respect (particularly towards elders, parents, women, and people in positions of authority)

These values form a strong foundation for thriving and resilient Pacific communities, a vision articulated by the Ministry of Pacific Peoples following an extensive Pacific community engagement process.

Of all population groups, Pacific peoples are most affected by inequities in the distribution of the socioeconomic determinants of health. Results from the census and other studies show that compared to all other ethnic groups, Pacific people are more likely to live in neighbourhoods of “high deprivation” and have the lowest median household incomes, higher unemployment rates, the lowest rates of home ownership, and the highest rates of household crowding. These factors affect health outcomes both directly and indirectly. Qualitative research has identified that Pacific peoples’ understandings of health and wellness are strongly underpinned by a narrative of poverty and limited resources. Pacific people are clear that unhealthy lifestyles are not due to a lack of knowledge, but a lack of economic resources and the ability to “make better choices”.

There are persistent and significant inequities in health outcomes for Pacific peoples. These outcomes are reflected by a lower life expectancy, higher rates of chronic disease, and premature disability. Pacific peoples have twice the rate of avoidable deaths (47.3%) compared to non-Māori, non-Pacific populations (23.2%). They are three times more likely to have diabetes than the general population and have a higher incidence of mental health disease than the general population, yet access mental health services at a much lower rate. Pacific children are also affected, with higher hospitalisation rates than all other ethnic groups for acute and chronic respiratory and infectious diseases and serious skin infections.

The health workforce has a central role in achieving equity. Initially, cultural competency was presented as a checklist of what the health professional should do if they were treating a person from a different culture e.g. ensuring a translator was available. However, it is now recognised that culture has a far more direct impact on health and is more complex than a checklist. This demands that as health professionals, we rise to the challenge of meeting cultural safety standards.

Cultural safety is defined by the Medical Council of New Zealand (MCNZ) as:

- The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and health care service delivery
- The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures, and characteristics that may affect the quality of care provided
- The awareness that cultural safety encompasses a critical consciousness where health care professionals and health care organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities

This updated statement, which replaces the Council’s statement on cultural competency from 2006, now places an emphasis on the health worker understanding their own culture and identity, and also recognises the power differential in the doctor-patient relationship. Ensuring that this power imbalance is not exacerbated by health workers overlaying their own cultural values and practices on patients, and challenging the cultural bias of individual colleagues or systemic bias within healthcare services, is paramount to moving towards health equity.

On a practical note, acting cultural safety starts with engaging in self-reflection and self-awareness. No-one can be expected to know
everything, so be open to learning from your patients. For example, if you are unsure how to pronounce a Pacific name, it is best to ask the patient first rather than trying to pronounce it and asking if you pronounced it correctly. It is better to admit your difficulties with Pacific names and ask for the patient's help and then, with their coaching, attempt their name. This approach shows respect for the person and their heritage, as well as an interest in learning more. Take the time to build a relationship with your patient and include their whānau when developing a diagnosis and treatment plan. Limit the use of medical jargon, and recognise that verbal and non-verbal communication styles may differ from your own — adapt as needed. For example, in many Pacific cultures, continued eye contact can be a sign of disrespect, especially when this involves looking at authority figures such as doctors. Don't assume that a lack of eye contact shows disinterest or annoyance. Similarly, it may be better for you to avoid prolonged eye contact with Pacific patients as that may make them feel uncomfortable, as if they are being scrutinised, criticised, or challenged. Of course, lack of eye contact could also be due to anxiety, anger, or fear, just as with any other patient. Look for other signals from the patient (or their whānau), and if you are unsure, ask the patient: “I’m concerned that I might be doing or saying something to make you feel uncomfortable. Can you tell me what you are thinking?” Good communication between health professionals and patients is a fundamental component of high-quality health services. Work effectively with interpreters and local hospital Pacific cultural support units when required. As health professionals, we must exercise caution in grouping all Pacific peoples together and making assumptions about “Pacific” preference.

Enabling Pacific people to control and improve their health will change demands in our health care system. It is never too early to reflect on how our own views and biases impact on clinical interactions and care that we provide to patients. Caring is fundamental to humanity. It is part of being human and it should not have cultural, social, or economic boundaries. I encourage all medical students to commit to cultural safety in the spirit of social responsibility. Cultural safety benefits all patients and communities.

References


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