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How does cultural safety embed into our consultation models? A critical reflection

Lucy O'Hagan[A,*] and Kyle Eggleton[B]

For full list of author affiliations and declarations see end of paper

***Correspondence to:**
Lucy O'Hagan
The Royal New Zealand College of General Practitioners, Wellington, New Zealand
Email: lucyohagan@gmail.com

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In recent years there has been increasing discourse around cultural safety in medical practice in Aotearoa. Both the New Zealand Medical Council's 2019 *Statement on Cultural Safety* and the 2023 *Cultural Safety Training Plan for Vocational Medicine in Aotearoa* from Te Ora and the Council of Medical Colleges set a bold vision for teaching cultural safety in all training programmes.[1,2] These statements are supported by ample evidence that culturally safe consultations can improve the patient's experience, increase levels of trust and ultimately reduce health inequities and improve medical outcomes for Māori whānau.[3]

Much of the discussion in these publications centre around the principles of cultural safety, institutional responses and the importance of critical reflection on the part of the practitioner. We are Pākehā general practitioners who teach both undergraduate and postgraduate communication skills. Our question is how can we integrate cultural safety into our current consultation models, to ensure that the rhetoric actually creates more culturally safe consultations with Māori whānau?

The most important contributions to improving consultations with Māori whānau, have been Hauora Māori models like Te Whare Tapa Wha and the Indigenous Health Framework comprising the Hui Process and the Meihana model.[4,5] The Meihana model's compelling image is of the whānau and patient as the double hulls of a waka (canoe) on a voyage to health and wellbeing. The Hui process is more directed at the consultation itself, with the essential ingredient being whakawhanaungatanga, a process of developing connections and building relationships. The message is that without relationships the practitioner will not be entrusted with the gift of the patient's story.

Our experience watching Māori faculty teaching these processes is that we gain a deeper understanding of Māori concepts of health, which challenge the biomedical separation of the mind body and the individualistic Eurocentric world view. We are also challenged with having a language for speaking about a spiritual life.

The Hui Process is aligned with the consultation structure of the Eurocentric Calgary-Cambridge model, widely used in our communication skills teaching.[4] The Calgary-Cambridge model and other Eurocentric models have had a beneficial effect on medical practice in the last 30 years, and still have a lot to offer in terms of specific communication skills needed to elicit the patient's story, negotiate and plan, and translate biomedical information into a language the patient understands. These skills are needed to effectively use the Hui process and Meihana model.

However, we have observed trainees who treat the Meihana model, Hui Process and Calgary-Cambridge model like a tick-box of things to cover. Information gathering without self-awareness does not build relationships and can become another head wind impairing the whānau's navigation of the health space. In addition we posit that ways of questioning and engaging are culturally determined and that the structure of the consultation may be more fluid or circular, involving intertwining of phases, than the Calgary-Cambridge model suggests.[6]

An element missing from most consultation models is the concept of critical self-reflection. According to Schön, reflection on action outside the consultation aims to become reflection in action during the consultation.[7] Culturally safe practice is achieved through a process of critical reflection by the practitioner reflecting on their own culture, biases and power differentials and considering how these can negatively impact the consultation.[8]

While the Meihana model includes an examination of culture, this is generally from the perspective of understanding the impact of colonisation on the patient. Critical reflection involves the decolonisation of the practitioner, which requires dismantling intellectual arrogance, being open to other world views and deconstructing social categories.[9] Decolonisation, within the consultation, necessitates an examination of privilege and how this shapes and forms our assumptions and interactions.[3] How this might look in a consultation could involve being aware of biomedical way of seeing; being prepared to listen for, acknowledge and incorporate a Māori view of health; and being aware of imposing a medical agenda.

A critical reflective approach to addressing bias in the consultation requires practitioners to acknowledge and interrogate their own assumptions. This might include a pedagogy of discomfort that can nurture a complex awareness of the lived realities of patients and the avoidance of superficial empathy.[10] Our own practice has been to consider any discomfort with using Indigenous models; to notice and address our own reactions, biases and responses; and to analyse our prescribing and referrals at the conclusion of consultations.

The final element of critical reflection missing from consultation models is an understanding of power. Power asymmetry is present from the very entrance into the practice, through to the positioning of desks, heights of chairs and the use of computer.[11] Other examples of asymmetrical power include having a flexible structure to the consultation; thinking about the prioritisation of issues and avoiding claiming power by giving unsolicited solutions and advice. In the context of culturally safe practice these Eurocentric power laden spaces and moments of time require reflection to make visible what is often invisible to the practitioner.

While the Indigenous Health Framework provides valuable guidance to creating a more culturally safe consultations, and the Calgary-Cambridge model provides essential micro-skills there remains a gap in how critical reflection is entwined into these consultation models. Cultural safety rhetoric must translate into our consultation models if we are going to improve consultations with Māori whānau and address inequity.

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Author affiliations
[A]The Royal New Zealand College of General Practitioners, Wellington, New Zealand.
[B]The University of Auckland, New Zealand.