ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

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Tēnā koe Joan

Draft statements on cultural competence and cultural safety and hauora Māori

Thank you for the opportunity to provide feedback on Council's draft statements on cultural competence, cultural safety and hauora Māori. As you will know, Toi Mata Hauora, the Association of Salaried Medical Specialists (ASMS) is the union for senior salaried doctors and dentists, representing over 6,000 members employed in New Zealand's health system. Toi Mata Hauora's approach to policy issues is guided by its constitution, and constitutional decisions are made by Toi Mata Hauora members via remits proposed at its annual national conference. In 2022, Toi Mata Hauora's national conference passed remits amending the constitution to advance and confirm a commitment to Te Tiriti o Waitangi and its principles.

Te Kaunihera Rata o Aotearoa, the Medical Council of New Zealand is the responsible authority for the medical profession in Aotearoa New Zealand under the Health Practitioner Competence Assurance Act 2003 (the Act). As noted in the consultation document, it is "responsible for setting standards of clinical competence, cultural competence (including competencies to enable respectful and effective interaction with Māori) and ethical conduct" under the Act.

ASMS strongly supports Council to set standards that clearly establish competent, safe, ethical conduct in all domains of clinical and professional medical practice. Council's work with the profession, experts and consumers to establish standards for culturally competent and culturally safe practice is highly regarded in the wider health sector, and have been a benchmark for colleges, unions and other professional groups since its first statement on cultural competence in 2005. We urge Council to continue its leadership within the health sector on the fundamental importance of cultural competence, cultural safety, hauora Māori, health equity and Te Tiriti o Waitangi.

A culturally competent workforce delivering culturally safe care (as defined by patients and whānau) must remain a standard that Health New Zealand, the Ministry of Health, workforce, unions and professional bodies do not lose sight of. Despite this, there is much work to do. ASMS hears regularly of health inequities, including those perpetuated and exacerbated by rationing of health care services. Recently we have heard of the following situations regarding nephrology services:

- Essential, life-prolonging dialysis services at Christchurch hospital are being rationed due to severe staff and space shortages(1).

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- There are three people stuck in Waikato Hospital for dialysis who cannot get back to Gisborne because there is no capacity for them to continue dialysis in Gisborne.
- People and whānau are travelling three hours multiple times a week between Murupara and Waikato Hospital for dialysis.

Our health system continues to bake in inequitable outcomes for kidney disease because the Ministry of Health do not classify chronic kidney disease as a long-term chronic health condition(2). This means that national data is not captured, including prevalence and risk at the primary care level, resulting in preventable deficits in planning for future demand, including medical and nursing workforces. Māori and Pacific Peoples are more than 5 fives likely to live with kidney failure compared to non-Māori, non-Pacific Peoples(2). In short: chronic kidney disease is a health outcome that is avoidable, systemic, unjust and unfair – the definition of an inequitable outcome. This is just one example of many.

We note the draft statements build on the Statement on Cultural Safety (2019) and He Ara Hauora Māori: A Pathway to Māori Health Equity (2019), the latter a companion paper developed to be read alongside the cultural safety standard. We support Council's decision to move to a Hauora Māori standard, and we encourage Council to continue to refer to the 2019 paper, as its status as a 'paper' rather than a 'standard' should mean that the review timeframes which standards are subject to are less rigid, and it can continue to the utilised.

ASMS recognises Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand. Our constitution affirms an active commitment to Te Tiriti o Waitangi and advocates for the highest possible standard of publicly funded health care services to be accessible to all New Zealanders.

Since 2019, Aotearoa New Zealand has experienced a global pandemic, where the Crown's response was found to have failed in ensuring equitable outcomes for Māori in the vaccine rollout and undermined their expertise(3). Major health reforms, including the establishment of Te Aka Whai Ora, the Māori Health Authority followed in 2022, only to be repealed as part of the coalition government's programme to narrow the application of Te Tiriti o Waitangi, and so-called "race-based" service provision in legislation and policy(4). The Treaty Principles Bill, Regulatory Standards Act 2025, and Healthy Futures (Pae Ora) Amendment Bill all seek to limit the Crown's Te Tiriti obligations, with the latter shifting towards minimal recognition and weakening of Te Tiriti commitments.

Nearly all doctors practicing in Aotearoa New Zealand have a relationship to the Crown: either being directly employed in the public health system, or in receipt of public funding through capitation, contracts or research funding. As agents of the Treaty partner (the Crown), doctors have a duty to uphold the obligations and principles as recognised by the health system: partnership, active protection, tino rangatiratanga, options and equity.

The development of skills, knowledge and expertise in cultural competence, cultural safety and hauora Māori is essential for medical practice in Aotearoa New Zealand. At its root, cultural competence and cultural safety are about connection and communication and understanding how power mediates these relationships.

ASMS sees the challenge for the health sector as one of realisation and delivery: there is a broad commitment as to the necessity and the value of cultural competence, cultural safety, Te Tiriti o

Waitangi and hauora Māori, but there is variable capacity and capability at institutional and individual levels in making it happen, without the right guidance, support, and resourcing.

Please find our responses to the consultation questions below.

Consultation questions

Statement on cultural competence and cultural safety

Is the draft statement on cultural competence and cultural safety clearly written and easy to understand?

Yes. The language used in the draft statement is clear and concise. The emphasis on plain language reduces risk of subjective interpretation and the use of second person perspective and maintains consistency with other Council statements.

Some sections of the statement would benefit from greater alignment to the definitions used in the Appendix. For example, the statement provides a list of ways a person may express identity, including, but not limited to indigeneity, ethnic, gender, sexuality, health status, and socioeconomic status. These all read as fixed and static, while the definition in the Appendix reflects an intersectional understanding, whereby identities are fluid, dynamic and overlapping.

The reference to both cultural competence and cultural safety as two distinct but related aspects is critical. Providing clear definitions that clarify the knowledge, skills and expertise of the doctor and the experience of the patient and their whānau reflects recent literature on the importance of this distinction(5).

Are the expectations in this statement reasonable and proportionate?

Somewhat. One of the significant differences between the 2019 statement and the current draft is the absence of the statement found in the “key points” box on page 1: Council requires doctors to meet the cultural safety standards outlined below.” As a practice standard, doctors reading the statement should be clear that they are required to meet the requirements as set out in the document.

Like many forms of expertise, cultural competence and cultural safety are built iteratively. Further, the development of skills in cultural competence, and creating conditions that enable cultural safety is not necessarily a linear journey from cultural destructiveness (active discrimination) and cultural blindness (treating everyone the same) through to cultural competence, proficiency, and safety. It would be beneficial for the section on Continuous Improvement to include an opening statement that gives greater context to the ways in which skills are developed, particularly where cultural safety as an outcome is not defined by an individual doctor. Statements such as “cultural safety is not something that can be ‘achieved’: rather it is a lifelong journey of continuous reflection and development”, offers a starting point(6).

Is there anything missing from the draft statement on cultural competence and cultural safety?

Individual doctors and the health system

We note the need to balance the tension between the standards individual doctors must meet for cultural competence, cultural safety and hauora Māori to practice in Aotearoa New Zealand while also advocating for change at the level of institution, structure and system as members of a collective profession. Clinical leadership and clinical governance provide avenues to enable clinical and professional skills, knowledge and expertise to inform and enhance the efficacy of health policy and systems design.

This is reflected in Council's own definition of the 'practice of medicine', where "The practice of medicine goes wider than clinical medicine, and includes teaching, research, medical or health management, in hospitals, clinics, general practices and community and institutional contexts, whether paid or voluntary."(7)

The relational nature of cultural competence and cultural safety can emphasise individuals and the person-level and tolerate culturally incompetent and culturally unsafe structures and systems at the institutional level. There is some irony in this, as it is systems themselves that establish and perpetuate discriminatory values and norms in the first place. ASMS agrees that "there remains an urgent need to move to thinking beyond individual responsibility, to developing culturally safe and competent organisations."(5)

Structural (re)volution in complex adaptive systems such as health is only possible when worked through collaborative, complementary top-down and bottom-up change processes, with the explicit involvement of governments, health system employers, decision-makers, health care workers and civil society.

By requiring clinicians to make meaningful change to culturally incompetent and unsafe institutions which in turn seek to limit the extent to which clinicians can safely speak against the actions of their employer and/or the government creates an expectation that could risk exacerbating moral injury, burnout and disengagement. Standards set an expectation for practice, but do not necessarily provide detailed guidance on how requirements might be operationalised or met in clinical practice; they are not operationally prescription by design. The gap between standard and practice, however, can reinforce norms at the systems level, which in turn prevents organisations and institutions from evolving, and "walking the talk".

For example, paragraph 4 "Take the worldviews of others into account your practice" includes a statement about a doctor changing their communication styles. One way to support greater cultural competence and improved health outcomes is to provide key information (such as patient letters) in the patient's first or preferred language. ASMS is currently waiting for advice from Health New Zealand on the availability and utilisation of its translation services, following members indicating they find these services difficult to access.

Cultural load

The section on cultural load recognises the additive demands placed on colleagues and patients from non-dominant and marginalised groups, for example – expectations of translation, guidance, and engagement. It does not acknowledge the profound distress and moral injury that comes from seeing

colleagues, patients and whānau experience racism, discrimination and the persistent weight of inequity. This form of cultural load should also be acknowledged in the statement.

Statement on hauora Māori

Is the draft statement on hauora Māori clearly written and easy to understand?

Yes. As with the statement on cultural competence and cultural safety, Council has taken a considered and precise approach to the wording used in the statement.

Are the expectations in this statement reasonable and proportionate?

ASMS sees the expectations as establishing a reasonable and proportionate for standard for doctors practicing in Aotearoa New Zealand.

Is there anything missing from the draft statement on Hauora Māori?

Significant differences between the 2019 paper and the 2026 statement are primarily in context, structure and perspective.

This is most notable the additional content and context provided in the 2019 paper on Te Tiriti o Waitangi and Aotearoa New Zealand's international obligations under the United Nations Declaration of the Rights of Indigenous Peoples (UNDRIP) which is not included in the current draft. Its absence underscores the 2026 statement as a Council standard rather than an information paper. This is not necessarily an absence which weakens the current draft; however, it does provide a succinct overview of the rights and needs based rationale for hauora Māori, health equity and inherent Indigenous rights to good health and wellbeing.

Further, the format of the standard (as opposed to the looser structure of the paper) means that guidance in relation to the work of health care organisations in hauora Māori is less prominent in the 2026 version.

The development of the 2019 paper (and the 2019 cultural safety standard) was the product of a significant collaborative project between Te Ohu Rata o Aotearoa (Te ORA, the Māori Medical Practitioners Association), and Council. This process emphasised an alignment and commitment to the need to incorporate cultural competence, safety, Te Tiriti o Waitangi and hauora Māori into vocational medical training and recertification for doctors, and was broadly supported by the medical colleges(8).

ASMS sees the whakapapa of Council's work on cultural safety and hauora Māori as important context for doctors in Aotearoa. As the current statement is a standard, the references and additional information provide context for readers. Access to cultural competency training, Te Tiriti o Waitangi, and hauora Māori remains variable, and international medical graduates experience challenges with cultural code switching, which encompasses aspects of cultural competency in relation to Te Ao Māori and "kiwi" norms and values(9).

Data sovereignty should be added to the sentence at point 7 "accurate, respectful, and aligned with national data protocols, including data sovereignty."

Do you have any other comments?

As noted above, changes in practice which improve cultural competence of doctors, create culturally safe experiences for patients and lift the organisational performance of health institutions is the work of doctors (individually and through their collective professional associations), their clinical and non-clinical colleagues, and the health system.

Council's role is to set the standard to be met: how the standard is met, including activities or actions undertaken by individuals and institutions, is not for Council to proscribe. However, there is a clear need for continued pressure on health organisations, especially where doctors are employed, educated, trained and represented to ensure they provide proactive, easily accessible guidance to support doctors to meet the cultural competence and cultural safety and hauora Māori standard, in the same way they provide resources for other areas of clinical competence and professional development.

Research by Te ORA and the HQSC has identified that Māori doctors have faced an increased cultural load in the workplace as emphasis on cultural safety has increased. This underscores the critical need for system level resourcing and guidance to support the development of culturally safe practice, without increasing the voluntary labour of Māori doctors, which is often unrecognised, unpaid, and performed outside of working hours.

Thank you for the opportunity to provide feedback on the draft statements on cultural competence and cultural safety, and hauora Māori. If you have further questions regarding ASMS' feedback, please contact Harriet Wild at harriet.wild@asms.org.nz.

Nāku noa, nā

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