



## Assessing the assessment: cultural competence and understandings of pain

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The burden of disease within Māori communities is well documented.<sup>1-3</sup> Research identifies that inadequate cultural competency contributes to health disparities between Māori and non-Māori New Zealanders.<sup>4,5</sup> The development and implementation of cultural competence training provides pathways for clinicians, to work more effectively with Māori as well as further opportunity for clinicians to engage in improving Māori health status.<sup>6-8</sup>

This issue of the *New Zealand Medical Journal* presents two papers by Magnusson and Fennell.<sup>9,10</sup> These papers provide a starting point to consider how the standardised assessment tools we work with can potentially lead to discounting Māori realities. Magnusson and Fennell used questionnaires and semi-structured interviews to evaluate the tools they use to explore and define the experience of pain. Although both studies featured small sample groups possessing high health literacy, they were comprised of participants who were able to comment from the perspective of a Māori patient as well as a Māori health stakeholder.

Magnusson and Fennell's research identifies and contributes several key understandings as to how we as clinicians can develop specific strategies to enhance our cultural competency practice.

Firstly, although the authors recognise the role of cultural differences in the expression of health, the acknowledgment of Māori as the indigenous peoples of New Zealand—rather than a minority ethnic group—would have strengthened their papers. Indigeneity and the experience of colonisation has moulded and influenced the culture of being 'Māori' in New Zealand, and has therefore fundamentally influenced Māori health. This acknowledgment would have assisted placing the findings within the context of Māori realities.

When exploring Māori health models the authors identified that like other cultures, health (and pain) is defined within a multi-dimensional framework. A holistic framework encompasses areas that are not included within a biomedical approach to exploring pain. They also identified that when using a Māori health model *Te Whare Tapa Wha* it is essential to establish and build a relationship of trust, use clear communication strategies and involve whānau (extended family) prior to utilising the standardised assessment tool.

Secondly, whilst clinicians may report that they understand what whānau means, unfortunately the strength of the collective community is seldom utilised in either the assessment or management of a patient.<sup>11</sup> Magnusson and Fennell's work adds to a growing body of literature<sup>12,13</sup> highlighting the importance of working alongside whānau to secure optimal clinical results for Māori.

Thirdly, the authors comment that when exploring the relevance of using the tools with Māori participants, very little te reo (Māori language) was offered as alternative phrases by participants. Readers should be cautious not to interpret these findings to mean that the use of te reo is not valued by Māori.

In our recent work<sup>14</sup> Māori participants clearly articulated the benefit of clinicians using te reo when it was initiated by the patient, and saw the use of te reo as a validation of them being accepted as Māori by the clinician.

Lastly, the differences between the standardised assessment tool did not highlight a difference between the way Māori and Pakeha (New Zealand European) express themselves, but showed a difference between how Māori and the biomedical community utilise words to describe pain. The biomedical approach requires a high level of health literacy and is based on a non-holistic framework of how pain and health is defined. Often within New Zealand we see things as a Pakeha vs Māori perspective, as opposed to a biomedical perspective vs a Māori perspective.

It is important for clinicians to eliminate jargon to ensure clarity when utilising standard assessment tools. A brief additional exploration of the patient's experience using a narrative approach may further clarify the experience of the patient. Participants recommended more common/colloquial terms to explore Māori patients' experiences of pain. This would ensure that both the clinician and patient were clear on what was being asked and communicated.

It would be of interest if the authors were to repeat their research with Pakeha and other ethnic groups to explore the differences between these ethnic groups and the biomedical cultural perspective.

The authors should be applauded for including the need to examine our standardised tools to the field of cultural competence, in addition to identifying what other approaches we may use that potentially contribute to ongoing health disparities between Māori and non-Māori New Zealanders.

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