



A resource booklet prepared for the
Medical Council of New Zealand by Mauri Ora Associates

Best health outcomes for Pacific Peoples: Practice implications



Acknowledgements

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The Council would like to formally acknowledge the contribution of the Expert Advisory Group: Dr Debbie Ryan, Dr Api Talemaitoga, Ava Fa'amoe, Tose Tuhipa, Metua Falasisila, and Sione Tu'itahi.

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Foreword



For New Zealand 2010 marks the dawn of the second decade of the new millennium. Today we are aware of our identity as a multicultural nation, and we recognise our Pacific context and the contribution Pacific communities are making to New Zealand society. We are also committed to ensuring that all New Zealanders enjoy good health and wellbeing, and to addressing disparities in health outcomes.

A culturally competent approach is defined as the health workforce increasing its knowledge and developing its skills around cultural awareness, understanding, sensitivity, and interaction. This is most commonly interpreted as addressing the cross cultural skills of individuals. However, a culturally competent approach should also recognise that addressing inequalities in health care means addressing barriers between different communities and health-care systems.

The low number of Pacific peoples in the health workforce reflects these barriers. Analysis by District Health Boards New Zealand shows that only 3 percent of the 60,000 people employed by DHBs are Pacific peoples.

These low numbers are inconsistent with the population as a whole, and are an obvious mismatch in areas where there are more Pacific peoples. Statistics show that in the greater Auckland region, Pacific peoples are under-represented in the health workforce, even though they make up almost a quarter of the population.

The need to address the mismatch between health services, the health workforce and Pacific peoples is compelling – the

Pacific population in New Zealand is expected to grow from the current nearly 7 percent to just over 12 percent by 2051.

Specific action to address the cultural competence of health systems and the health workforce is critical. Taking specific action will ensure that health services meet the needs of different ethnic groups and that the services are designed and delivered in a way that people will choose to use them. This resource on cultural competence makes a significant contribution to how this can be achieved. There is no right answer, only a journey of development as we seek greater knowledge, understanding and effectiveness.

I was privileged to be part of a group of Pacific health workers and community leaders who worked on these issues. I would like to acknowledge the work of the Pacific Advisory Group. Special tribute is due to the leadership of Lita Foliaki and Dr Siale Foliaki, who shaped the project, and to the work of the Mauri Ora team.

The Samoan proverb 'o le taeao afua' refers to the new dawn. This publication contributes to a new dawn of understanding of the requirements for working with Pacific peoples, families, and communities. This understanding will ensure there is high-quality health care leading to improved health outcomes and reduced inequalities for Pacific peoples.

Dr Debbie Ryan

Introduction



This resource booklet is designed to assist branch advisory bodies and help doctors to meet the cultural competence requirements of the Health Practitioners Competence Assurance Act 2003 (HPCAA) and to improve the health outcomes of all Pacific peoples. The booklet complements the Council's *Statement on Cultural Competence* and the *Best Health Outcomes for Māori: Practice Implications* resource.

The booklet offers guidance on the cultural diversity of and cultural preferences for Pacific peoples in New Zealand. The description of Pacific culture in this booklet is necessarily generalised because there are at least 22 separate Pacific nations,^{*} each with its own culture and history.

Pacific peoples born in New Zealand also have their own distinctive cultural habits. Like people of all other populations, every Pacific person will have his or her own preferences and beliefs. Doctors need to learn each patient's preferences – be they Tongan, Samoan, Māori, Chinese, or European – and to try to put them at ease by creating and maintaining a respectful and trusting therapeutic relationship.

While the ideal way to learn about Pacific peoples is to live within a Pacific community, connections can also be made by interacting with Pacific peoples in formal learning situations, sports events, churches, community groups, and other Pacific organisations in your local area. General Pacific knowledge can also be gained from reading Pacific publications such as *Voyages* (www.voyages.net.nz).

* Cook Islands and Niue are sovereign self-governing states in free association with New Zealand (established in 1965 and 1974 respectively), which means that all people born in Cook Islands or Niue are automatically New Zealand citizens. Tokelau is a non-self-governing territory of New Zealand and also shares citizenship with New Zealand. Hence the term 'Pacific peoples' does not automatically mean 'migrant', because most Pacific peoples are in fact New Zealand citizens by right of birth in New Zealand, Cook Islands, Niue, or Tokelau.

Background evidence



Migration to the Pacific and New Zealand

Current thinking is that waves of migrants from South-East Asia first reached the islands of the South Seas between 5000 and 1500 BCE. In highly sophisticated ocean-going vessels, these voyagers reached Micronesia, then Fiji, Tonga and Samoa. They then travelled eastward to the Cook, Society and Marquesas Groups, and from there crossed thousands of miles of open ocean to colonise the islands of Hawai'i in the north, Easter Island in the southeast, and New Zealand in the southwest.¹⁴

Pacific peoples in New Zealand

Pacific peoples first migrated to New Zealand some 1200 years ago, becoming the indigenous Māori.³ In modern times, the most significant arrival of Pacific peoples to New Zealand was between the 1950s and 1970s when immigration controls were relaxed, and the post-war economy provided work.

In 1968, the Department of Māori and Island Affairs was formed. One of its chief responsibilities was to work with Pacific Island immigrants.⁴⁷

The oil crisis in the 1970s caused an economic downturn in New Zealand. Despite the tightening of immigration policy and high unemployment rates, Pacific peoples continued to work in the manufacturing and service sectors. During the 1976 government election campaign, Pacific peoples were labelled 'overstayers', resulting in 'dawn raids' where police and immigration officials executed searches through their homes looking for people who had overstayed their work permits. This had a deep impact on the community and today is still seen as a decisive event in New Zealand–Pacific relations.

Partly because of these issues, in the 1970s Pacific peoples in New Zealand developed as an organised political force and the 'Pacific voice' was presented to Government. The first Minister of Pacific Island Affairs was appointed in 1984, and the joint Department of Māori and Island Affairs was disbanded in favour of separate organisations for each group. This move gave each group its own voice and enabled programmes and interventions to be specifically targeted.

In New Zealand, 'Pacific' usually refers to people of Samoan, Tongan, Cook Islands, Fijian, Niue, Tokelauan, or Tuvaluan descent, although there are also people from French Polynesia, Kiribati, Papua New Guinea and the Solomon Islands in the country. The term is also used to refer to people of mixed ancestry, including multiple Pacific cultures, as well as Pacific-non-Pacific backgrounds.³³

While this document uses the term 'Pacific peoples' as a broadly accepted convention to refer to those whose cultures originate among the islands of the South Pacific and share certain attributes, it is important to remember that the act of grouping tends to mask the differences amongst those who have been grouped.

Like the term 'Asians', 'Africans', and 'Muslims', the inclusive term 'Pacific peoples' or terms such as 'Pacific Nations people', 'tangata pasifika', 'tagata pasefika', 'Pasifika peoples', 'Pacific Islanders', and 'PIs'⁶¹ misleadingly group together a wide range of people with distinct languages, heritages, national origins, and ethnic affiliations. This grouping,⁷ creates a false impression of uniformity within and amongst the different groups.³³ Pacific communities within New Zealand are diverse. Inter-marriage among these groups, as well as with the broader New Zealand population, has provided a further level of complexity.³³

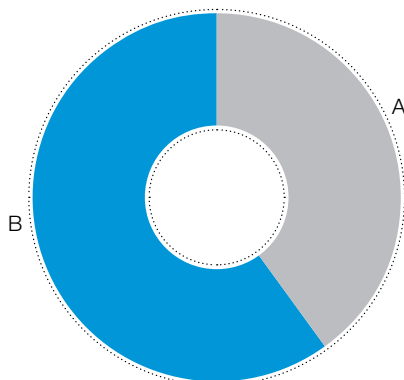
Statistics – living in New Zealand

The majority of Pacific peoples living in New Zealand were born here.

According to the 2006 census, more than half of the Pacific children born between 2002 and 2004 had more than one ethnicity and nearly a quarter had more than one Pacific ethnicity.¹¹ In addition, 7 percent of Māori also claimed Pacific ancestry in the same census.⁵⁷ This means that every person must be approached as a unique individual, rather than as the representative of a larger, homogeneous group.³³

In the 2006 census, nearly 7 percent (300,000) of the total New Zealand population identified themselves as Pacific. This was a 15 percent increase from the 2001 census, and the second-biggest increase amongst all ethnicities.

Pacific People Living in New Zealand: Birth Location

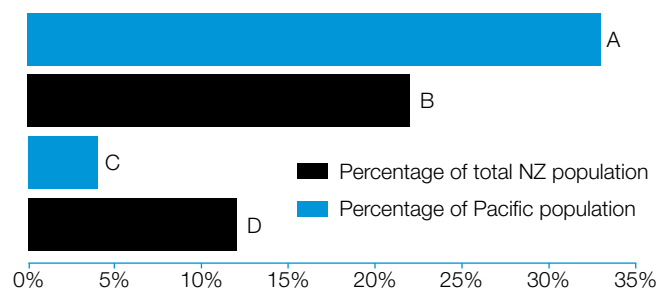


- A Born in New Zealand – 40%
- B Born overseas – 60%

Our Pacific population is projected to continue growing faster than the European population, with the Pacific population estimated to increase from 300,000 in 2006 to 480,000 by 2026. The composition of the Pacific population is also changing because of the community's higher fertility rates and younger age structure. The median age among Pacific peoples is 21 years – 14 years below the median age for the general population.⁵⁸

Two-thirds of Pacific peoples live within the area of DHBs in the Auckland region, whilst another 11 percent live in Capital and Coast, Hutt Valley, Waikato or Canterbury DHB areas.²⁹

Age Distribution of Total NZ vs Pacific NZ Population



- A Pacific under 15 years – 33%
- B Total under 15 years – 22%
- C Pacific over 65 years – 4%
- D Total over 65 years – 12%

Summary points – history of Pacific peoples in New Zealand

- The most significant modern movement of Pacific people to New Zealand was between the 1950s and 1970s.
- Economic woes in the mid-1970s led to tightening of immigration policies, prosecution of 'overstayers', and the emergence of Pacific peoples as a political force within New Zealand.
- The majority of Pacific peoples now living in New Zealand were born here.
- Nearly 7 percent of the total New Zealand population identify themselves as Pacific and most live in the Auckland region.

Summary point – Pacific cultures are diverse

- Exercise caution in grouping all Pacific peoples together and making assumptions about 'Pacific' preference.

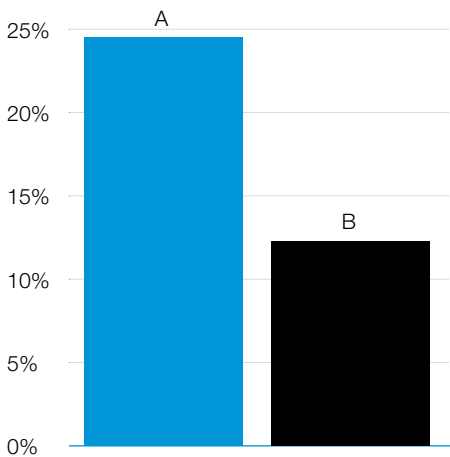
Pacific health

The health outcomes of Pacific peoples are worse when compared with the general population in New Zealand. These outcomes are reflected in lower life expectancy, higher rates of chronic disease, and premature disability.^{33,34}

For example, Pacific peoples:

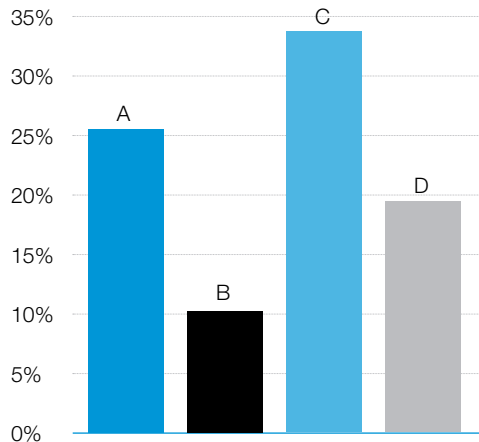
- are three times more likely to have diabetes than the general population²⁹
- are more likely to be severely disabled, with a higher proportion of disabled children or young adults
- have nearly twice the rate of avoidable mortality and ambulatory-sensitive hospitalisations as other New Zealanders³⁷
- have a higher incidence of mental health disease than the general population, yet access mental health services, even for serious disorders, at a much lower rate.

Disabled Population with Severe Disability



- A Pacific people – 24%
- B Non Pacific People – 12%

Disabled Population with Severe Disability



- A Children Pacific – 25%
- B Children European – 10%
- C Young Adult Pacific – 33%
- D Young Adult European – 19%

Pacific children have higher hospitalisation rates (compared to non-Pacific, non-Māori children) for multiple diseases, including:

- respiratory diseases (2.5 times higher)
- asthma (3 times higher)
- cellulitis (5.5 times higher)
- gastroenteritis (1.3 times higher)
- dental conditions (3 times higher)
- kidney and urinary infections (over 2 times higher).

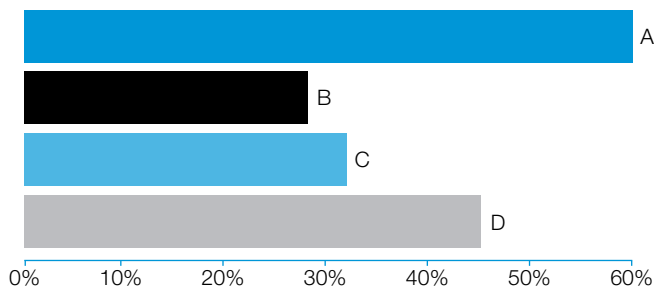
Effects on the community

The burden of illness and disability is reflected in less than ideal outcomes for individual Pacific people, as well as for communities as a whole. Because of the community-oriented nature of traditional Pacific culture, one person's negative experience is likely to be shared with their extended family, as well as the broader community. This influences the entire group's perceptions and future behaviours.^{17,22,63}

Negative experiences may also reinforce stereotypes within the health practitioner community. If a practitioner doesn't understand the cause of a Pacific patient's confusion or dissatisfaction, he or she cannot prevent similar experiences with other patients.²⁵

Although demographic information often refers to ‘Māori and Pacific peoples’, there are significant differences between Māori and Pacific communities. For example, teenage smoking rates are quite different between the two communities.^{32,36}

Teen Smoking Rates by Ethnicity & Gender

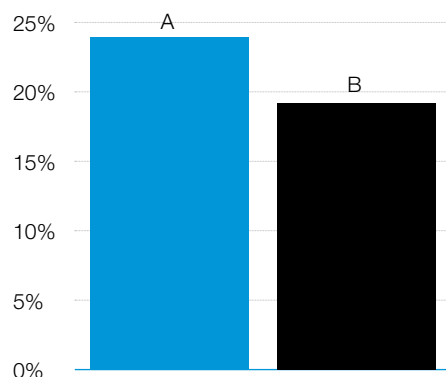


- A Māori Girls – 60%
- B Pacific Girls – 28%
- C Māori Boys – 32%
- D Pacific Boys – 46%

There are also differences between Pacific communities; Schaaf et al demonstrated that compared with Tongan women, Samoan and Cook Island Māori women had higher ten-year cardiovascular risk scores. For men, individual risk factors varied, with Cook Island Māori having significantly higher total cholesterol, blood pressure and urinary microalbumin than other Pacific Island ethnic groups, while Tongan men had lower HDL levels.⁴⁸

There are also different patterns for how Pacific populations use mental health services. These are due to different ethnic backgrounds and differing migrant experiences. Historically, Pacific peoples were thought to have low rates of mental disorder, but *Te Rau Hinengaro: The New Zealand Mental Health Survey* in 2006 showed that this is not the case.³⁹

Mental Disorders: 12 month prevalence



- A Pacific people – 24.4%
- B Non Pacific People – 19.3%

Pacific peoples born in New Zealand or those who have moved here before the age of 12 years have twice the rate of mental disorders as people who moved after the age of 18 years.³⁹ Among those with serious mental disorders, Pacific peoples accessed services at a significantly lower rate.³⁹

Summary points – differences in health between Pacific populations

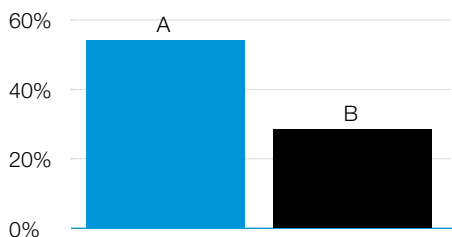
- The health of Pacific peoples is worse than that of the general population.
- Māori and Pacific populations can differ significantly in many measures of health; there are also differences within and between different Pacific populations (for example, cardiovascular risk scores for Tongan and Samoan populations).

Pacific health inequalities

Pacific peoples are disproportionately represented in lower socioeconomic brackets.

- Compared to 8 percent of the total population, 27 percent of Pacific peoples meet the criteria for living in severe hardship.
- 15 percent live in significant hardship.
- Only 1 percent report ‘very good living standards’.²⁸
- Home ownership rates are much lower in the Pacific community and Pacific peoples are more likely to experience overcrowding in their homes.²⁸
- Unemployment rates are almost twice as high within Pacific communities.²⁸

Home Ownership Rates



- A Total NZ – 55%
- B Pacific People – 26%

While all of these factors contribute to the health status of Pacific peoples,²⁸ disparities in overall health persist even when factors such as poverty, education, and location are eliminated. This difference demonstrates that culture determines health status independently of socioeconomic factors.^{27,50}

Common health disparities in Pacific communities

Health disparities are noticeable throughout Pacific communities. Overall, the life expectancy for Pacific peoples is nearly five years less for men and just over four years less for women when compared with men and women in the New Zealand population.³³ Although there is some evidence² that ethnic inequalities in mortality may no longer be widening, the recent improvement in mortality for New Zealanders overall has been less apparent for Pacific groups.

The leading cause of death in Pacific communities is cardiovascular disease. The mortality rates for both cardiovascular and cerebrovascular disease are consistently higher among Pacific peoples than in the rest of the New Zealand population.^{12,29} Among adults, Pacific peoples have three times the risk of death from stroke compared to the general New Zealand population and twice the rate of ischemic heart disease.³⁷

Over the past 25 years, disparities in cancer survival rates have increased. Pacific men have higher rates of lung and liver cancer, and Pacific women have higher rates of breast and cervical cancers, compared with the rest of the New Zealand population.²⁹

Infant mortality is higher among Pacific peoples, even though Pacific infants have a good distribution of birth weight. Pacific children have above-average risks of infection, including serious infections such as meningococcal meningitis and rheumatic fever. Pacific children are more likely to be admitted to hospital for asthma and are at higher risk for burns and pedestrian injuries.^{29,37}

Other measures of health, such as avoidable mortality, participating in screening programmes, and access to specialists, are significantly worse than for non-Pacific populations.³³ Despite having access to primary health-care services, Pacific peoples present less frequently for breast and cervical cancers screening, have lower than average rates of surgical admission to hospital, and lower rates of specialist visits.³⁷

Healthy lifestyle choices, as well as targeted public awareness campaigns, are also disproportionately poor in Pacific communities. Pacific children and adults are more likely than non-Pacific peoples to be physically inactive and to smoke. There are higher obesity rates in the Pacific community for both adults and children, contributing to the higher incidence of diabetes.³⁷

In the disabled community, Pacific peoples are disproportionately represented in the most socioeconomically deprived areas.³⁵ Yet parents or caregivers of disabled Pacific children are less likely to receive the child disability allowance than their non-Pacific peers.³⁵ This lower use of entitlements (despite higher levels of financial need) is consistent with the lower ACC claim rates also seen in the Pacific community.³⁵

Summary points – health disparities

- Health disparities exist in all parts of the Pacific communities, even after socioeconomic status and other factors are controlled for, especially in rates of cardiovascular disease, cancer, and infant mortality.
- Despite being more likely than any other group to enrol in the national diabetic programme Pacific peoples have lower than average results.
- Pacific peoples turn up for GP appointments at higher rates but experience worse outcomes and receive fewer referrals, despite having a higher burden of disease.

Different approaches to treatment



There is compelling evidence³⁷ that although Pacific peoples access the health system, they do not achieve the same benefits as other groups.

Different patients have different expectations of their providers that, if not appreciated, can lead to miscommunication and poor outcomes. Several studies have demonstrated the importance of doctors asking about their Pacific patients' health-related beliefs.^{8,33,40}

Pacific patients generally expect to spend time building a close rapport with their general practitioner (GP). If this does not happen, or if the patient feels rushed, then Pacific patients may develop a negative picture of their doctor, which in turn can affect their use of the health system.^{33,40}

Health care and Pacific patients

Studies have consistently demonstrated that some doctors treat patients differently based on ethnicity. Examples of this include the findings of the 2001–2002 *National Primary Medical Care Survey (NatMedCa), Report 7*.¹⁶ General practitioners reported that they were less likely to have a high level of rapport with their Pacific patients, ordered fewer tests, and referred patients to specialists less often, despite their greater and more complex health needs.

Although Pacific peoples have a high enrolment rate with Primary Health Organisations (PHOs) and high attendance rates with their GPs, many measures show that the health-care system is not as effective in providing care to Pacific peoples. For example:

- Pacific children are less likely to be fully vaccinated at two years of age than the national average

- Pacific women used cervical and breast screening services one-third less often³⁷
- Pacific peoples are less likely to have received counselling or advice about stopping smoking³⁷
- Pacific peoples are referred to specialists at lower rates (20 percent versus the national average of 30 percent), with access to surgical care particularly problematic³⁷
- Pacific peoples with disabilities are also less likely to have received a needs assessment than their non-Pacific peers.³⁷

Although Pacific communities are familiar with and do seek care from primary care services, they continue to have less than ideal outcomes. This suggests that they are not receiving the most 'appropriate treatment' from these services.³⁷

One aspect of appropriate treatment is to provide information in a form that the Pacific patient finds both understandable and acceptable, so that they can keep to treatment recommendations. Two percent of Pacific peoples reported being treated unfairly by a health professional because of their ethnicity (compared with 0.6 percent of European/others, 1.3 percent of Asian, and 2 percent of Māori people). Research strongly links self-reported experience of racial discrimination with a range of negative health outcomes in New Zealand adults.^{21,33}

Cultural misunderstanding and unconscious bias have contributed to the state of Pacific health. Integrating cultural with clinical competence should lead to better outcomes by:

- improving communication
- making treatment more acceptable
- improving adherence to treatment plans
- measuring of doctor performance in delivery of services to Pacific peoples.^{1,6,15,24}

Summary points – the New Zealand health-care system does not always meet the needs of Pacific patients and their families

- Despite seeking care appropriately, Pacific people often don't receive the high quality, timely services they need.
- Pacific patients and their families may expect different things from their doctor than non-Pacific families; for example, they may place a high value on spending time getting to know the doctor.
- Cultural misunderstanding by doctors can contribute to Pacific health disparities.

Cultural competence and clinical competence



Research shows that health professionals who are familiar with their patients' cultural heritage are likely to offer improved patient care,²⁵ making cultural competency 'essential for high quality healthcare'.⁹ The Health Practitioners Competence Assurance Act 2003 requires all registration bodies, including the Council, to establish standards for clinical and cultural competence.

In a series of articles in 2004, Dr Ian St George described how to establish and assess competency standards in the health-care setting. Current recertification requirements incorporate many of these ideas.^{51-56 52-56 †}

EXPLODING MYTHS

A case study about conventional wisdom

Dr Smith and Dr Manning are friends from medical school who have met up at an annual medical conference. They sit down to talk shop and share some of the problems they face in their practices.

'To be honest, I'm finding it really hard to avoid getting callous,' Dr Manning sighed. 'Some patients are so uninterested in taking care of themselves that it's hard for me to feel concern for them. It's terrible to say, but sometimes I feel like, if they can't be bothered to care, then why should I?'

Dr Smith nodded vigorously. 'I know exactly what you mean. And the obesity numbers – it looks like things are getting worse, not better. The Pacific patients in my practice are all so unmotivated and unhealthy! What's worse, when I try to talk to them about it, to tell them what they need to do differently, they always agree with me, but then they never change! It's enough to make me give up. I catch myself spending as little time with them as possible, since I know I'm wasting my breath. It's really sad, but I suppose there's nothing we can do about it. It's just a cultural thing.'

'Really? I don't agree. I don't think Pacific people want to be unhealthy any more than other groups do,' Dr Manning objected, frowning. 'I used to have problems with my Pacific patients, too, but since I changed how I do things with them, I've been really pleased.'

'If you've figured out the secret, share it with me,' Dr Smith replied sarcastically. 'I can't get anywhere with those people.'

'Well, first off, I realised that if I wasn't having any effect, then doing the same old thing wasn't going to work.'

The other man nodded grudgingly. 'Okay, that makes sense.'

[†] Branch advisory bodies such as the Australasian Faculty of Public Health Medicine (AFPHM) and the Royal New Zealand College of General Practitioners (RNZCGP) have begun to address the need to assess cultural competence alongside clinical competence in their recertification requirements.

'So I decided to get to know the community better and see if they really were as uninterested as I thought. I was surprised to find a lot of interest out there – I work in an area with mostly Samoans and Tongans. I worked with two of the local churches and a community group, and I gave some talks on diabetes and heart disease. Then they asked me back for a sort of free-form question and answer session. Boy, did that open my eyes.'

'How so?'

'A lot of people came, and they all had lots of questions. I'd thought Pacific people were really fatalistic about their health and didn't want us to give them much information, but they were all eager to learn more. They said they find it really frustrating not to be told more, and when I checked in the literature, I found that really was the case – patients want information, but in a way they can understand.'

'I explain things very well!' Dr Smith argued. 'My patients never ask me any questions.'

'Well, a lot of Pacific patients won't ask questions unless you ask them to. I realised I was often explaining things to patients the same way I'd talk to another doctor, so they really didn't understand me half the time. I didn't even figure out I was doing that until I started asking patients to explain things back to me.'

'What? Why would you do that? That would take forever!'

'It doesn't really, and it lets me make sure that I explained things to them clearly. I've caught a lot of misunderstandings since I started doing that. I also find that by 'politely demanding' that they tell me what they think, I get past the "yes, Doctor" polite answer.'

'Aha! You get that too!'

'I used to. I didn't realise it was just my patients' way of being polite and not contradicting someone who they hold in high regard.'

'You? Obviously they haven't heard about the time in uni when you –'

'Yes, me. You can stop laughing. You know – a doctor's high status is true in most Pacific cultures, so my patients were uncomfortable telling me "no" or that my treatment plan wouldn't work for them. When I started building better relationships with them and asking them to tell me what they thought of my recommendations, it made it easier for them to express concern or dissatisfaction. Once they started doing that, then we could work out a plan that they would actually follow and start to see results.'

'You make it sound simple. It can't possibly be that easy.'

'It is and it isn't. I mean, it takes time at first, when you need to get to know the people – making social small talk about them and their families as well as sharing stuff about yourself.'

'That's unprofessional! I don't feel comfortable talking about myself and my family with patients. Besides, why would they care about my life? I'm their doctor, not their friend. I shouldn't take up time from their consultation for non-essential chit chat, let alone talking about myself instead of them.'

'No, no. I know what you're saying, but in a lot of cultures, until the patient knows who you are, who your people are, and what kind of person you are, they don't feel comfortable with you. That means they won't be able to express their concerns or tell you when they have a problem. Once you connect with them, they trust you and will follow your advice. I used to think that communication was easy – just talking – but believe me, it's pretty complicated. Still, I find that if you make the effort, it really pays off.'

'Well, I'm still not convinced, but I guess I'll give your method a try. I'm certainly not having much success and I'm tired of having my patients contributing to these health inequalities.'

'Give it a try – isn't there someone else in your practice who can help, like your partners or practice nurse? And there are a bunch of online resources available too. Good luck!'

The impact of culture on health



Because culture plays an important role in health, health providers should be aware of their patients' specific cultural preferences. With Pacific peoples, key issues need to be addressed so that the patient can achieve the best possible outcome.

Doctors who recognise that their Pacific patients provide a unique opportunity to learn about a variety of Pacific cultural values, can use this understanding in working with all patients and their families.¹⁹

A GOOD OUTCOME

A case study about asking questions

Mr Toleafoa, a 32-year-old Samoan man, tried to prevent a fight at a social gathering and was punched in the face, falling backwards onto a concrete floor. He was unconscious for about five minutes, but regained consciousness shortly before Emergency Medical Services (EMS) arrived. He was assessed at a Glasgow Coma Scale (GCS) of 15 by EMS at 02.20 and taken to the local emergency department (ED).

He was first assessed by a doctor at 03.45 – one hour after presenting to the ED. His GCS was then a 12. When the physician, Dr Sinclair, heard that Mr Toleafoa was Samoan and was injured in a fight at a party, he decided that Mr Toleafoa was intoxicated

and may have a head injury. He decided not to order any imaging studies and admitted Mr Toleafoa for observation.

Due to overcrowding, the only available bed was in the urology ward. While Mr Toleafoa was waiting to be sent to the ward, he became very agitated. Mrs Toleafoa was worried by her husband's uncharacteristic behaviour.

Mr Toleafoa doesn't drink alcohol and he is normally extremely pleasant and easy-going. He doesn't use vulgar language and is a lay preacher at his church. In the ED, however, he was combative and cursed the staff in extremely rude language. Now he was mumbling nonsense and Mrs Toleafoa wasn't sure what to do. The ED was very hectic, and staff members were all obviously busy, so she was hesitant to bother them. She felt embarrassed that her husband was acting so strangely and didn't know why. She decided to stay quiet – after all, Dr Sinclair and the nurses had examined Mr Toleafoa, and they must know what they're doing.

Nurse Fong was keeping an eye on Mr Toleafoa while his own nurse took a quick break. He went in and noted a restless patient with a bruised face who was apparently talking to his wife. He saw that Mrs Toleafoa looked scared and worried.

'How are you feeling, Mr Toleafoa?' he asked, but the patient ignored him, keeping his eyes closed. He looked at Mrs Toleafoa, who looked at the ground.

'Mrs Toleafoa, how are you doing?'

'I – I'm all right, thank you.'

'We're going to be taking Mr Toleafoa upstairs to a room soon. I'm sorry it's taken so long.'

'Oh, that's all right, I know you're taking good care of him and that you're very busy.'

'It's certainly busy tonight! Still, we should get you upstairs where it's quieter soon.'

'That will be good. I think the noise is upsetting my husband.'

'Yes, it can have that effect. Tell me, how much did Mr Toleafoa have to drink tonight?'

'He had about six cans of Coke, and I think he had some coffee with dinner.'

'No, no. I mean, how much alcohol did he have?'

'Oh, my husband doesn't drink.'

'Ever?'

'No, never.'

'Hmm.' Nurse Fong checked the chart again. No blood alcohol level was drawn. It looked as if someone had assumed that since Mr Toleafoa was at a party, he must have been drinking. Nurse Fong was now concerned that Mr Toleafoa's behaviour wasn't alcohol-related.

'Mr Toleafoa? Mr Toleafoa?' The patient continued to ignore him and to mumble.

'Mrs Toleafoa, what is he saying?'

Mrs Toleafoa looked surprised, 'I don't know.'

'Don't you speak Samoan?'

'Yes, I speak Samoan, but my husband isn't speaking Samoan. That's just nonsense what he's saying.'

Now Nurse Fong was very alarmed. 'Mrs Toleafoa, is your husband acting in his normal way?'

'No, ever since we got here, he's been very odd. He's normally very polite and quiet, yet he's been shouting and swearing. I'm very sorry – it's not at all like him to be this way. He will be very ashamed of himself when he feels better.'

'Did anyone tell you about the signs of a head injury and ask you to let us know if Mr Toleafoa displays any of them?'

'No.'

'I'll be right back.'

Nurse Fong hurried over to Dr Sinclair and explained what he had just learnt. Dr Sinclair returned to the patient, alarmed to find that his GCS was now 10. He confirmed that Mr Toleafoa had had no alcohol that night, nor any other mind-altering substance, and that he was acting in a very uncharacteristic fashion. He too had assumed that Mr Toleafoa was speaking Samoan when he couldn't understand him, and was worried when Mrs Toleafoa assured him that the patient was simply rambling.

A computed axial tomography (CAT or CT) scan was immediately performed and an epidural haematoma diagnosed. Mr Toleafoa was taken to the operating room and eventually made a full recovery.

NOTE: This case is based on an actual Health and Disability Commissioner report. In that case, however, no one checked whether the patient was speaking Samoan or acting characteristically, and the diagnosis was not made until it was too late. The patient died. (HDC Canterbury Report, full report at: http://www.hdc.org.NewZealand/files/hdc/publications/other_canterburyreport.pdf)

Key concepts for Pacific peoples



The key to understanding health behaviours of Pacific peoples is to see issues from their worldview. In this section, we highlight common and important concepts that continue to guide many of the Pacific peoples in New Zealand.

Relationships – family, community, environment

The family is the basic unit of organisation in Pacific society, with individualism less of a focus and less celebrated than in non-Pacific society.

‘Family’ refers not only to the nuclear family, but – more often than not – to the extended family. For many Pacific people, each person’s role is defined by the family, so personal contribution to the family in turn defines the individual. Family conveys interconnectedness a system of interrelated obligations, responsibilities and benefits.

For many Pacific peoples, it is important to create and maintain good relationships within the family, and beyond to other families, friends and community. Pacific peoples often work to balance relationships between people and with the surrounding environment.

Holistic health and spirituality

In Pacific societies, good health is a holistic concept that extends beyond the physical world. Pacific peoples see life and wellness as gifts, and as incorporating physical, mental, social, and spiritual wellbeing. One’s ability to fully participate in family and community life is directly associated with being ‘fully healthy’. Being healthy is associated with being a more

productive member of family and community, whereas being unhealthy or unwell is associated with the shame and embarrassment of not being able to contribute fully to one’s family and community.

Contribution and responsibility

Because one’s contribution is a key aspect of wellbeing, responsibility has a huge influence on the way a Pacific person conducts their life. This creates a desire and duty to provide for and support family and community financially, emotionally, practically, and spiritually.

This responsibility begins with taking care of family, and revolves around ensuring the future of children. Relationships with friends, professionals and community are characterised by integrity, the ability to give, generosity and mutual benefit, so that a Pacific person can meet all their obligations.

Correctness and respect

For Pacific peoples, the way things are done is important. An example is Fa’a Samoa, the Samoan Way. This is an all-encompassing concept dictating how Samoans should behave. It refers to the obligations a Samoan owes to their family, community and church, and a person’s sense of Samoan identity.

Respect is also very important. Samoans are expected always to show respect for those of higher social status; this includes older people, matai (those with chiefly authority, hereditary village leaders), ministers, politicians, doctors and teachers.

Faith

Spiritual faith (the belief that there is a greater power than oneself, namely God) is important throughout the Pacific. Since the 1700s, Christianity and the church have played a central role in Pacific culture and life. For example, Pacific churches act as a meeting place and an organising force for community projects.

FAITH AND FATE

A case study about religion

Dr Chin's patient, Mrs Pukapuka, is a 39-year-old Tokelauan woman with breast cancer. Dr Chin is very concerned that Mrs Pukapuka has 'given up', because when they discuss her different treatment options, she frequently says, 'It's in the Lord's hands. I know He will take care of me.'

Dr Chin interprets this as Mrs Pukapuka having decided there's nothing medicine can do to help her. He therefore doesn't discuss very aggressive treatment options with her, focusing more on helping with quality of life issues.

At the next visit, Mrs Pukapuka's sister, Mrs D comes with her, and she surprises Dr Chin with a question about enrolling Mrs Pukapuka in a clinical trial. 'My neighbour has breast cancer too, and her doctor put her in this new study. She had to have surgery and now she's on this new drug, and they say it might cure her.'

'Well, that's the hope of every new drug,' Dr Chin explains, 'but the trial takes a very aggressive approach to the treatment. There would be surgery, chemotherapy, and it is a very gruelling regimen. I don't think your sister would be interested in that.'

'Why not?'

'Mrs Pukapuka has a more fatalistic approach. She says that it's in the Lord's hands and –'

'But, Doctor, we believe that everything is in the Lord's hands. That doesn't mean we don't try to help Him out! The Lord brought us to you so that you could give my sister the best treatment possible. If you think this new drug might help her, of course

we want to try it, and the Lord will help our family get through the struggle.'

Now that Dr Chin understands that Mrs Pukapuka's faith doesn't prevent her from being interested in any and all treatment options, including those with a high degree of intervention, he is able to discuss treatment more effectively and comprehensively with Mrs Pukapuka and her family, so that they can make the most informed choices possible.

With the encouragement of Mrs D and the rest of her family, Mrs Pukapuka decides to enrol in the clinical trial. With the support of her family, her church, and Dr Chin, she tolerates the treatment very well.

Integrity and dignity

This concept includes both the formal, solemn processes that Pacific peoples observe when meeting and interacting with others, as well as a sense of individual poise and pride. Both reflect the importance of keeping to proper behaviour.

Dignity can also play an important part in medical experiences for Pacific peoples. A person's concern for their dignity may, in cases, outweigh concerns about their health, especially if health issues are not explained properly. If a doctor doesn't reassure the patient that their dignity will be respected, the patient may refuse certain procedures. This is particularly true of invasive medical interventions, such as a digital rectum examination for prostate cancer.

Dr Mason Durie has commented:

“The degree of comfort individuals feel with seeking health services impacts on their use of services and, in turn, health outcomes... The delivery of care in a culturally appropriate manner is an important element in determining both the willingness of people to access services and the success of any treatment or care then delivered.¹⁸”

The most effective and enjoyable way for providers to understand the communities they serve is to have an open mind. This, coupled with a commitment to effective communication and a desire for helpful feedback, will lead to an educational approach that extends beyond the moment to a lifetime of learning.

Summary points – cultural competence will improve health care

- Beware of over-generalisations, especially when dealing with Pacific peoples; always treat patients as individuals and verify any assumptions you make about them.
- The extended family is the basic unit of organisation in Pacific society, and reciprocal obligations to and from the family are very important. Because of this, Pacific people often bring family members to their medical appointments and/or may want to consult with them before accepting treatment recommendations.
- Health is a holistic concept for Pacific peoples and is not limited to physical illness (or the lack thereof).
- Many Pacific people value respect and spiritual faith, as well as proper behaviour and conduct. Pacific people may interpret informality, especially in the absence of a long-standing relationship, as disrespect or discourtesy.

Principles of culturally competent care for Pacific peoples



The differences between New Zealand-born and migrant Pacific peoples

There are many differences between New Zealand-born and migrant Pacific peoples.

The traditional outlook, which includes an unquestioning demand for respect and process, doesn't always fit comfortably for a younger, New Zealand-born generation. Younger generations must often try to balance the demands of a conservative (or more traditionally-based) Pacific society with their own view of the world, which is increasingly gathered from overseas education and experience.

These differences can create division within the Pacific. A key example is around language; those who can speak the native language of the community may judge those who cannot, as lacking. Monolingual Pacific peoples may feel 'incomplete' and dislocated from family or social interactions.

Pacific-born Pacific peoples commonly:⁶²

- have a strong sense of 'who they are' and 'where they come from'
- are deeply connected to their birth village
- are less concerned about the opinions of those outside their 'group'
- prioritise family and social responsibilities over physical health

- view New Zealand as a source of income for meeting family and cultural responsibilities.

New Zealand-born Pacific peoples commonly:⁶²

- care about 'who they are' and 'where they come from'
- give less priority to cultural and church responsibilities
- experience conflict with family members when community responsibilities clash with their own needs
- are conditioned to copy Western behaviour.

A sense of identity

It is important to note that the term 'Pacific-born' or 'New Zealand-born' can be considered an insult.

A doctor's thoughts and questions should revolve around how a person was raised, their environment, life experiences and values. Through conversations with the patient, the doctor will gradually get to know them, but be aware that – as for the rest of us – the patient's sense of identity and self-knowledge may change over time.

*I am a Samoan – but not a Samoan
To my aiga in Samoa, I am a palagi [foreigner]
I am a New Zealander – but not a New Zealander
To New Zealanders, I am a bloody coconut, at worst,
A Pacific Islander, at best,
To my Samoan parents, I am their child.*

While this verse relates a Samoan experience, it encapsulates the paradox of identity for many New Zealand-born Pacific peoples. In many Pacific Island communities they are 'not Pacific enough'; rather they are seen as wanting to be European. In the wider New Zealand community, Pacific Islanders are often identified not as being New Zealanders, but rather as 'coconuts', or 'FOBs' (fresh off the boat). Some may develop a secure self-identity despite these perceptions, but others may experience confusion.⁴

Pacific Islanders with a broader ethnic identity in New Zealand call themselves PIs, Polys, or New Zealand-born. They have developed new music, fashion, customs and ways of speaking. This distinctive identity is sometimes referred to as Pasifika Aotearoa. Some young PIs are heavily influenced by Afro-American youth culture in their dress, slang, body language and music, especially hip hop and rhythm and blues. A unique culture has emerged within the Pacific people of South Auckland, who contribute culturally to the Ōtara market and the Secondary Schools Cultural Festival.⁶⁰

Interconnectedness

The cultural structure to which a particular Pacific patient belongs depends on a combination of geography, life experience, closeness to other families and kin, and maintenance of active lines of communication – often between countries. Pacific culture is extremely dynamic, and what is 'normal' is constantly being redefined.

Many modern urban Pacific families embrace connectedness, duty, obligation and mutual benefit within their daily lives. The problems of dysfunctional Pacific families, who are affected by drugs, alcohol, violence and/or sexual abuse, may be compounded by the complex interconnections, duties, reciprocities, and intricacies of wider family bonds and community obligations. These issues need be addressed in the wider community to be effective and acceptable.

Because of this 'interconnectedness', it is common for Pacific patients to bring family or friends with them to medical appointments, or to consult with them before accepting any treatment recommendations. Some people may feel more comfortable if another family member speaks on their behalf.

At times this can lead to a slightly longer interview so that the group can consult before making decisions, but as well as providing greater comfort to the patient, the presence of other relatives and community members can lead to improved care. For example, family members can provide additional background information during the medical history, and can help the patient to understand your instructions and carry out treatment.

Summary points – principles that guide culturally competent care

- There are often numerous differences between New Zealand-born and migrant Pacific peoples.
- Use of the terms 'Pacific-born' and 'New Zealand-born' can be considered insulting by some. Focus less on asking where a person was born and more on learning about their upbringing, life experiences, beliefs, and values.
- Pacific culture is very dynamic, and what is 'normal' is constantly being redefined.



Ethnicity data collection and use

Collecting ethnicity data accurately and consistently is essential to providing the best clinical care. Without this – and information such as educational level, religious affiliation, lifestyle, marital status, and dietary habits – health providers will be unable to provide individually-based care.

Doctors should make it a standard part of their practice to ask every patient what their ethnic background is; do not make assumptions based upon skin colour, name, or appearance. By asking the question, show respect for the patient's individual heritage, but also have an opening to discuss their cultural preferences.

For all patients, explain why, how and when background information will be used, and reassure them that, like all medical information, the information is treated as confidential. It is also critical not to argue with or challenge the patient's view of their ethnic affiliation.[§]

Some patients may identify themselves as being multi-ethnic, such as Samoan/Irish/Māori or Tokelauan/Niue, while others of Pacific ancestry may choose not to. However, if you ask questions in a consistent manner, explaining yourself fully and giving the patient enough time to answer, it is unlikely that anyone will find a question about ethnicity inappropriate or offensive.

In fact, you may find that your patients welcome the opportunity to share how they see their cultural heritage and their health interacting. For example, if a patient were to say, 'Oh, my family's Samoan (or Tongan or Italian or Māori), and food is an important part of family life, so there's no way I will ever not be overweight. There's nothing I can do about it', you could listen and then offer nutritional advice that is still culturally sensitive, or suggest an exercise programme that could counteract dietary indiscretions.

'BUT YOU DON'T LOOK...'

A case study on assumptions

Dr Bauer has recently joined a practice that routinely gathers ethnicity data on all patients. Dr Bauer hasn't done this in the past and he thinks it is rude and potentially offensive to ask such a thing. He prefers to make an educated guess based on the patient's

appearance, name, occupation, behaviour, and conversation, and he prides himself on rarely being wrong.

He has just finished seeing a new patient, Mrs Garcia, when she glances over at his notes and comments, 'Oh, Doctor, you have my ethnicity down wrong. I'm actually Samoan.'

'Really?' he asks in surprise. 'But I assumed you were European. Your surname –'

'My husband is from Spain; I'm not.'

'I see. Well, I must say, you don't look like a typical Samoan.'

Mrs Garcia frowns at him. 'Yes, I get that a lot, but I must say I don't appreciate it. In my family, we're very proud to have Chinese, English, Māori, Samoan, and Tongan ancestry, but I really consider myself Samoan.'

'I'm sorry. I was making some assumptions, and I appreciate your helping me to recognise that. It sounds like your family has a great deal to be proud of. There must be some fascinating stories that your older relatives can tell.'

Mrs Garcia smiles. 'Why, thank you. Yes, I am very lucky.'

Knowing that Samoan women are at a disproportionately high risk for certain conditions, Dr Bauer discusses this with Mrs Garcia and they agree to run a few screening tests.

Summary points – collecting and using ethnicity data

- Collecting and using ethnicity data accurately and consistently is essential to providing high quality medical care.
- Make it a standard part of your practice to ask every patient about their ethnic background; don't make assumptions based on name or appearance.

[§] Reported examples such as 'You don't look Samoan to me' or 'But you have blue eyes – how can you be Tongan?' should be avoided.

The central place of effective communications

Cultural competence can improve communication between you and your patient to achieve the best possible health outcome for the patient.

Some communication styles associated with Pacific peoples include:

- paraphrasing or speaking metaphorically – for example, they might use ‘first house of baby’ for womb
- needing more time to express themselves
- adults tend to be highly verbal and respond well to animation, facial gestures, drama, and long, meaningful conversations
- enjoying humour.

It’s important to explain health-care information so that the patient understands the topic. Just because someone appears to speak ‘good’ English doesn’t mean they fully understand everything, especially complex health issues. Always check a patient’s understanding by asking them to repeat things back to you in their own words.

Family members can help you to make sure the patient has received enough accurate information and to check on any misunderstandings and disagreements. Many Pacific peoples feel that the patient’s role is to receive treatment, while the role of the family is to support the patient and negotiate with authority figures.

There are several ways to create time to speak with the patient privately. For example, you may need to ask a question about sexual behaviour, drug use or another topic that the patient may be uncomfortable with or unwilling to discuss in front of family members. In that case, it is entirely appropriate to ask family members to step outside while you do this. If you feel this would be inappropriate, you can also wait until you are alone with the patient for another reason and ask them.

Summary points – culturally competent communication

- Cultural competence can enhance communication between your patient and you.
- Do not assume that speaking ‘good’ English is synonymous with understanding explanations about complex health topics; always confirm a patient’s comprehension by, for example, having them explain the treatment plan in their own words.
- Many Pacific peoples feel that the role of the family is to support the patient by interacting with the physician, while the patient assumes a more passive role.
- Do not assume that silence means consent.
- Politely require that your patients ask you questions and/or share their thoughts and opinions. Without this encouragement, many Pacific peoples will feel it is inappropriate or rude to express their concerns or disagreement to you.

Guidance on Pacific preferences



Be guided by each patient and their family when it comes to individual cultural practices. If you make assumptions based on broad stereotypes, you are likely to end up embarrassing your patient, and weakening the doctor-patient relationship, rather than strengthening it. For example, rather than greeting all Pacific patients with a Samoan greeting, you can first ask them about their background and only then use the appropriate greeting.

While most patients appreciate your efforts to put them at ease by acknowledging their culture and showing your respect for it, they are less likely to be appreciative if you misidentify their culture. For example, if your patient is a Tongan woman married to a Samoan man, you might assume from the surname that she is Samoan, but she might prefer to be greeted in Tongan.

It is important to be aware of gender issues and the evolving nature of society when working with Pacific peoples.⁵ The following examples are typical issues that may be important to a Pacific patient; they are not meant to suggest that every person of Pacific culture will feel the same way about any or all of these.

Initial contacts and protocols

The key to interacting with Pacific peoples is to build a connection that allows open communication.

Taking the time at the first meeting with the patient (and their family) to let them learn about the practice team will lead to more effective relationships. Practice team members should

introduce themselves when they first meet a Pacific patient and explain the job they have within the practice. This includes the reception staff who, after establishing these connections, could then explain after-hours arrangements, how to make an appointment, and how to pay medical fees. A small investment of time at a first meeting and during future visits will pay off in a longstanding, close relationship with not only the patient but their whole family.

You might spend a few minutes at the start of every appointment catching up with your patient about their family. By doing so, you are acknowledging those relationships, the importance they have to your patient's life, and your understanding of connections in Pacific culture. You will be re-establishing and building the doctor-patient relationship, before you move to the clinical part of the consultation.

'WHAT DID YOU CALL ME?'

A case study about pronunciation

Dr Jones is a GP who has recently begun working in an area of Auckland with a large Tongan population. She would like to develop close relationships with her patients and encourages them to call her 'Dr Anna'. She in turn calls them by their first names. She is unfamiliar with many of the names but is concerned that showing her ignorance would be offensive, so she pronounces them as best she can, assuming that her patients will correct her if necessary.

One day, she meets a new patient, 'Alo, an 18-year-old Tongan man who was injured at his workplace. He turns up with several members of his family. She greets him by name, calling him 'Alo. She notes that he becomes quiet and several of the younger children snicker, but no one says anything to her, and she assumes he is simply shy.

To put him at his ease, she uses his name often during the conversation and tries to make eye contact, but as the consultation progresses, the patient becomes more withdrawn. Despite numerous questions to him, it is difficult to get anything but very short answers, and she ends up speaking mostly with his mother. Dr Jones decides that, like many Pacific men in her experience, he simply isn't interested in taking part in his own health care.

It is only after the patient and his family have left that Dr Jones mentions 'Alo to one of the practice nurses, who is also Tongan. The nurse exclaims, 'Oh, dear – is that how you pronounced his name?'

'Yes,' answers Dr Jones blankly.

'In Tongan, the name 'Alo is pronounced like the words "a lot" without the "t", but the word alo – pronounced like the word "halo" without the "h" – means a bad smell. Did you ask the patient how to pronounce his name?'

'No, but why didn't he correct me? That's what I do when someone mispronounces my name.'

'In Tongan culture, it would have been very rude to correct you, since as a doctor you have a high status. But that also means that you have the responsibility to make sure that he feels comfortable sharing things with you. You could have made a "polite demand" that he correct your pronunciation or share any concerns with you. That would have given him the chance to explain the right way to say his name.'

Dr Jones is very upset at how she accidentally insulted her patient before his entire family. She asks her nurse to coach her on the proper pronunciation of the patient's first name and surname, then calls him to apologise and explain her error. The patient was surprised but pleased by the apology and, at her request, he promised to help her improve her Tongan

at his next appointment by teaching her a simple expression like 'hello' or 'thank you'. Confident that 'Alo won't be reluctant to attend his follow up because of her actions, Dr Jones nevertheless sends him a quick note, repeating her apology in writing and telling him that she's looking forward to seeing him at his next appointment.

When 'Alo appears, along with his family, for his follow-up, Dr Jones repeats her apology before the entire family, but it's clear that it has now become very much a funny family story to them, and not a source of offence. Before long, even the children are helping Dr Jones learn Tongan phrases, and her acceptance in the community is assured.

Pacific pronunciation and communication

Few Pacific patients have access to Pacific health providers, and the different cultural backgrounds between a doctor and their patient can hamper communication. This difficulty can be lessened by developing a understanding of Pacific language and communication. Learning how to pronounce Pacific names correctly is a great way to show respect for your Pacific patients.

If you are not sure how to pronounce a Pacific name, it is best to ask the patient first rather than trying to pronounce it and then asking if you got it right. It is better to admit your difficulties with Pacific names and ask for the patient's help, then, with their coaching, to attempt their name. This approach shows respect for the person and their heritage, as well as an interest in learning more.

While Pacific peoples' languages are very similar, there are varying ranges of pronunciation. Samoan pronunciation is very simple, and consonants are almost nearly identical to English consonants. The Samoan word for 'thank you,' – fa'afetai – is pronounced 'fah-ah-faytie'. The Samoan 'g' sound can be difficult for some foreigners to master. It's pronounced similarly to the 'ng' in 'sing along'; for example, the Samoan word for gun – faga – is pronounced as 'fah-ngah. The 'n' sound is also pronounced as 'ng' by Samoans. In Samoan words, all syllables are given equal timing with a slight accent placed on the second to last syllable.

Some common Samoan greetings and their English translations are: talofa – hello; fa’afetai – thank you; tofa – goodbye; lau susuga – sir.

Pacific peoples may be less likely to challenge treatment plans or ask questions than many non-Pacific patients, but their silence doesn’t necessarily mean understanding or agreement on their part. This, coupled with the shyness which is common to many patients before a health practitioner, makes it vital that you fully explain:

- what you are doing and why
- what you believe is wrong with the patient
- how you recommend treating the condition
- what medications you are prescribing and why (along with how they should be taken)
- what results (both positive and negative) you expect.

Do not wait to be prompted about this; make it a basic part of your discussions with the patient. Then be sure to ask whether the patient (and their family) have understood what you said and whether they agree. It is important to be sure that the answer you think you are getting is the one that the patient really means.

FINDING OUT THE UNDERLYING PROBLEM

A case study about communication

Mrs Vahalahi is a Niuean woman in her late 60s with diabetes. Her former GP, with whom she had a very good doctor-patient relationship, retired recently, so she found a new GP, Dr Lee, in her neighbourhood. At her first appointment, Dr Lee changed her medications. Mrs Vahalahi didn’t really follow his explanation of why he had done so, but she was reluctant to bother him or his nurse with questions.

The new medication gave Mrs Vahalahi diarrhoea, so she returned to Dr Lee. She didn’t feel comfortable talking about her diarrhoea with him or challenging his choice of medicine, so she simply asked if she could go back to her old medicine.

‘No, Mrs Vahalahi. I put you on the new medicine for a reason,’ said Dr Lee. He smiled to himself, thinking that older patients were very resistant to change,

even when it was change for the better. He knew he had done the right thing in putting her on the new medication, as the literature was very clear that it was the best choice for someone in Mrs Vahalahi’s situation and would give the best result.

‘Oh. All right,’ said Mrs Vahalahi quietly. She decided that she would just stop taking the medicine rather than deal with the side effects.

Dr Lee saw that Mrs Vahalahi didn’t look very happy. ‘Why do you want to switch back?’ he asked, curious. ‘What’s better about the old medicine?’

‘This new one, it upsets my stomach,’ Mrs Vahalahi answered. ‘I’m sure it’s a very good medicine, but maybe it’s not so good for me.’

Now Dr Lee understood. ‘No, you’re right, Mrs Vahalahi. A lot of people when they first get on this medicine have the same problem you do, but there are things we can do to improve that side effect. It doesn’t last very long either – your body just has to get used to it. Do you think you’d be willing to try the new medicine for a few more weeks? There’s such good evidence that this medicine can help your condition that I think it would really be worth the try. If you’re still having problems at the end of that time, I’d be happy to switch you back – I just want to be sure you’re on the best medicines possible, but I promise I won’t keep you on any pill that makes you feel worse.’

‘All right, Doctor. I’ll make that deal with you. Let’s see how I feel in a few more weeks.’

Lastly, be careful using medical jargon with patients.²⁶

This not only refers to specialised terms, like ‘myocardial infarction’ instead of heart attack, ‘cerebrovascular accident’ instead of stroke, or ‘adenocarcinoma’ instead of cancer, but also – and perhaps even more importantly – to ordinary words, such as ‘complain’, ‘deny’, ‘report’ or ‘claim’ that have a specialised meaning in a medical context. For example, a patient who overhears a nurse say to a doctor, ‘Mrs Faumuina is here, complaining of a headache for the last two days,’ may think that the nurse is accusing Mrs Faumuina of complaining, not recognising that she is using the word ‘complain’ in its medical sense. Similarly, a family may be offended if the doctor writes, ‘Family denies drug

use on the part of the patient', because they assume the term 'deny' implies disbelief on the doctor's part; if she had believed them, she would simply have written, 'Patient did not use drugs.' In all of these cases, a simple explanation will avoid or address hurt feelings.

Summary points – using Pacific languages appropriately

- Learning how to pronounce Pacific names correctly is an excellent way to show respect for your Pacific patients.
- Ask for help with pronunciation before attempting an unfamiliar name or word.
- Give everyday explanations for information such as test results or medication instructions, so that your patients fully understand their condition and your treatment plan, rather than relying on printed instructions.

Communication with Pacific families

It is very important that a medical team recognises that a Pacific patient may want family members to be involved in all aspects of their care and decision making. This involvement may vary across different families and cultures. It is not possible to generalise about how families wish to be involved with a patient's medical experience, so be sure to ask each patient what he or she prefers.

VALUE OF COMMUNICATION

A case study about checking assumptions

Mr Levu is a 58-year-old Fijian ex-smoker with heart disease. He has had diabetes for many years and was well-controlled on his medicine. Two years ago, he had a Coronary Artery Bypass Graft (CABG) and was started on insulin shortly thereafter. He also began inhaler treatment to maximise his pulmonary function. Since his surgery, he has separated from his wife and his HbA1C levels remain high (>15).

Dr Sino, a Samoan intern, has spoken with Mr Levu about his illness and marital separation, and the change in his diet and lifestyle now that he lives with his sister. Mr Levu has been counselled to take his medication, but nothing seems to help.

Dr Sino asks her practice nurse, who she knows has a close relationship with Mr Levu's family, for her views on the case. The nurse says that Mr Levu told her that his surgery had gone very badly and he was expected to die soon. Mr Levu is understandably very upset about this.

Dr Sino is astonished. The CABG was very successful and she is not sure why Mr Levu feels he is less healthy than before. She had assumed Mr Levu was as pleased with the results of the operation as she and the surgeon were.

Dr Sino sits down with Mr Levu and reassures him that he is not dying, but that the new medications and surgery have actually helped to improve his health and give him the ability to do more things. After several more discussions like this with Mr Levu and his family, within four months Mr Levu's HbA1C drops to 6.2.

Examining patients

As in many cultures it is polite to ask permission before touching or examining a person. After introducing yourself to the patient and any family members present, you should, before beginning any physical examination, explain briefly what you will do, why you are doing it, and ask permission to go ahead. Be aware that, depending upon the examination, some family members may choose to stay with the patient. You should ask the patient and family what they prefer, rather than automatically asking family members to leave the room (or to stay behind) while you make your examination.

Pacific patients may wear an adornment. If so, only remove it if it is a safety hazard. It may be better to tape it in place than to remove it; ask about this. If the adornment poses a risk to the patient or the medical team, ask permission from the patient and/or family before removing it and, if possible, allow a family member to remove the adornment and keep it safe.

Physical contact

In Pacific cultures, there are varying beliefs about physical contact between the patient and physician. Explaining and discussing practices clearly and in advance will help to put people at ease and to determine what is appropriate for each patient.

Body language

Body language can be different between Pacific and non-Pacific peoples. An example is the lack of eye contact a doctor may experience with a Pacific person. In many Pacific cultures, continued eye contact can be a sign of disrespect, especially when this involves gazing at authority figures such as doctors and nurses in a medical practice or hospital. 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.

Although lack of eye contact could be a sign of respect, it could also be due to anxiety, anger, boredom, inattention, or fear, just as with any other patient. You will need to look for other signals from the patient (or their family) to decide what is happening in a particular case. If you are unsure about this or any other non-verbal signal, 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?'

While direct, sustained eye contact may be off-putting to some, turning to face the patient (even if direct eye contact is not made) will show your wish to establish a connection. *The Pacific Island primary health care utilisation study* found that if Pacific patients felt that their consultation was hurried, they equated that with a lack of interest on the part of the GP.⁴⁰ Make sure that your body language shows a willingness to take the time to get to know the patient. Placing yourself side-on to them so that you can at the same time type notes into your computer, could be taken as showing a lack of interest and attention, if not as outright rudeness.

NONVERBAL MESSAGES:

A case study about body language

Ms Ward spent several weeks trying to find a doctor for her elderly Niuean mother, Mrs Pavihi, after her mother's long-term doctor retired. She finally found Dr Smith, who seemed to be perfect. She came highly recommended, had impressive credentials, had a practice near Mrs Pavihi's home, and had extensive office hours.

She wasn't able to accompany her mother to the first appointment, but asked her about it later that day. 'Did you like Dr Smith, Mama?'

'I don't think I'll go back. She doesn't know very much.'

'What do you mean? She's a very smart lady. Everyone says she's a good doctor.'

'I don't see how she can be. She never even looked at me. She just looked at her computer screen and tap-tap-tapped away, making notes. She never even turned away from the machine and faced me! She never paid any attention to me or what I was telling her.'

'She didn't spend any time asking about me, just wanted to know about my bowels and my heart and all my other parts, as if that tells her anything about me. She only wanted to know about the sick parts of the body; she didn't want to know about me.'

'Besides, everyone in that office was running around. Rush, rush, rush! I barely had time to take my coat off and they were hurrying me from one place to another. They must have too many patients – they can't spend any time with the ones they have, let alone meet new ones. I want a doctor who will get to know me and how I am doing, not just ask me about my sugar and my heart!'

Sharing information and consent

Since many Pacific people consider their own health problem as a community problem, they may feel threatened if their family members are excluded from medical interactions, consultations, decisions, or procedures. Give patients the chance to tell you who they would like to have present and how much information they would like you to share with the others. Be guided by the patient's preferences, rather than by general notions about overall Pacific (or non-Pacific) culture.

There are times when you will need to be discreet, particularly when using family members as interpreters. While this may be convenient, it can also create problems. For example, using an abusive husband as the interpreter for his wife may make it impossible for you to discover the underlying abuse. Another example might be the impropriety and discomfort caused when asking a New Zealand-born grandson to translate for his grandmother when she wishes to consult you about a gynaecological disorder.

With informed consent, Pacific peoples are like all other patients in needing as much information as possible, often presented in several ways. Also, they may wish their family to be given the information, and to have the chance to discuss the matter with them before giving consent. Silence may not mean agreement, so when getting informed consent, be sure to ask about the patient's understanding and bring out concerns with open-ended questions.

'WHO WANTS TO KNOW?'

A case study about privacy

Mr Taorangi is a 60-year-old Cook Island Māori man who is hospitalised for a prostatectomy. His daughter is a nurse in the Cook Islands, and she telephones the hospital for information. Unfortunately, the staff on the hospital ward refuse to give out patient information and refuse the daughter's request to 'ask my father. He's right there and will give his consent.'

Because Ms Taorangi is a registered nurse, the family was relying on her to advise them about what was happening. She needed the information about her father's condition to do that. Although Mr Taorangi speaks 'good' English, this is deceptive, as his understanding, particularly of medical English, is not

very strong. The medical staff, however, misjudged his comprehension and tended to interact only with him, rather than speaking with other members of the family, including his daughter.

It took several phone calls before Ms Taorangi was able to make her father's doctors understand the situation. Once that happened, and she was given medical updates, she could then reassure her parents and make sure they understood what was happening. She was also instrumental in helping the medical team set up a post-operative care plan.

Often Pacific families will nominate the most health-literate member of the family to interpret or advocate for them and the patient. It is helpful for doctors to communicate with this person to make sure that there is good understanding on both sides. Letting the family spokesperson know the timeframes in which you require a decision, or in which certain activities will take place, can avoid frustration or confusion on both sides.

When using an interpreter, speak directly to the patient, so that you can read their body language and emotional responses. Prompt the interpreter (especially if this is a family member and not a professionally-trained interpreter) to ask the question just as you say it.

Summary points – communicating clearly when giving information and seeking consent

- Some Pacific peoples may feel threatened or abandoned if their family members are excluded from consultations or procedures. Be sure to ask about the patient's preferences.
- Remember that silence doesn't necessarily mean consent.
- Some Pacific families may choose to appoint one person as advocate or liaison for them and the patient. It is usually very helpful to work with this person to ensure good communication and trust.

Traditional medicine

Traditional Pacific medical practices not only deal with medicinal plants and their uses but also with the physical, emotional, mental, and spiritual welfare of the person. Traditional healing practices help cure life's everyday ailments and common injuries.

Traditionally, Pacific peoples believe that life is the union of body, emotions, mind, and soul or spirit. Health is a state of balance of several opposing aspects within the human body, as well as between the human body and the environment. Illness happens when a person falls out of balance physically, emotionally, mentally or spiritually.

Traditional medicine approaches diagnosis and treatment holistically. It considers a person within an ecological context and usually will not simply look after the sick part of the body. As well as providing treatment, practitioners of traditional medicine often give advice on lifestyles and healthy behaviour.

Traditional medicine is based on individual needs. Different people may receive different treatment, even if they suffer from the same disease. Traditional medicine believes that each person has his or her own constitution and social circumstances, which result in different reactions to the 'causes of diseases' and treatment.⁶⁶

The traditional healer

In ancient times, most Pacific peoples believed that supernatural forces caused illness. If a person got sick, it might be thought that a spirit was displeased with their behaviour, or that of one of their relatives. It might be thought that they were suffering from hidden guilt or a secret wrongdoing. It might even be suspected that another person had cursed them. The person and the traditional healer might also decide that the patient had broken a taboo, eaten unwholesome food, or suffered from too much emotional or sexual passion.

When a sick person went to a healer, the patient would review their recent actions to try to determine what might have given offence. The patient would describe any symptoms to the healer, who would perform or direct proper corrective measures. This might have included a special diet to bring about a state of balance in the person.

Historically, Pacific peoples did not consider biological agents such as bacteria and viruses as the causes of disease. A Pacific person always tried to discover the nature

of the offence which caused the illness. So-called 'incurable' diseases that resulted in death were believed to be under the control of the gods, and whether a patient recovered or died was dictated by the superior will and desires of the gods.

Current traditional practices

Massage involving the whole body (or parts of it) is one of the most commonly used medical treatments throughout the Pacific. Massage treatments are used to cure headaches and muscular pains, to tone the body after childbirth, to correct a clubfoot and other malformations, to ease healing sprains, and during pregnancy.

All Pacific cultures have a healthy appreciation for bathing, whether in fresh water or the sea. People wash frequently, and might use certain leaves which lather like soap, rub sand in their hair to clean the scalp, remove grime from their skins with oil, and use wadded fibres from coconut husks and other plants to scrub their bodies.

Healers throughout the Pacific use plant medicines in the form of potions and applications. Most commonly, they prepare medicines from selected plants by pounding the material in a wooden bowl and straining the juice. Sometimes the juice may be sweetened with sugar cane sap and drunk with water, inhaled or applied to an injury.⁴⁵

Some Pacific cures

- *Pacific peoples use smooth stones and shells in massage, and to relieve stress, tension, aches, tiredness, muscle strains, and general unwellness.*
- *In Tahiti, to relieve pain and infection, soft mud is smeared over scalds and superficial burns and allowed to dry in place.*
- *In Tahiti and Samoa, breast milk is applied to the eyes to rid them of conjunctivitis.*
- *Fijians may use urine on bee and jellyfish stings to stop the pain and itching.*
- *Kava is crushed and drunk to relieve headaches, tension and sleeplessness. A kava poultice is also used in Hawaii to stop toothache.*
- *Fijians and Hawaiians may use turmeric root, which is cleaned, then pounded and mixed with hot water, strained and squeezed to produce a juice used to relieve diabetes and coughs.*

- *The cut end of the stem between a taro corm and leaf is rubbed onto insect bites to reduce itching, pain and swelling.*
- *Raw kukui or candlenut is eaten as a laxative in Hawaii.*
- *In Tonga, women scrape tree bark to get sap which they apply to the tongue and mouth of children to treat thrush.*
- *Fresh green ti leaves are directly applied to the forehead to cool the brow and relieve headaches.*
- *The juice of the moist husk of green coconuts is squeezed and administered to newborn babies to clear their systems of 'womb' food.*
- *Coconut oil scented with fragrant leaves and flowers is used in massage for aches, pains, injuries, vitality, and beauty.*
- *The people of Rapa Nui (Easter Island) use sweet potatoes to quench their thirst. Hawaiian women may use sweet potato vines as a necklace to ensure an abundant flow of breast milk.*
- *Samoans may apply urine to eliminate styes in the eye.*
- *Throughout the Pacific, people use the juice of the noni for its curative powers.*

A potential problem with traditional Pacific medicine is that it can be seen as 'victim blaming' and may bring about shame in the patient and the family, because of the link between illness and inappropriate behaviour by the individual or family member. This can be particularly difficult for the family, since many medical conditions are not the result of moral wrongdoing or the breaking of social tapu.

The Western medical diagnosis can at times be very liberating for Pacific patients and their families. The patient and their family may prefer the medical explanation may be preferable to the patient and family, as it does not cause feelings of guilt or shame. However, it is extremely important for doctors to give honest reasons for their diagnosis, without belittling traditional beliefs held by a patient or family.

Whether your patient believes that their illness is due to a violation of tapu, clogged arteries, misaligned chakras, insufficient vitamin C, or evil spirits, your role is not to challenge their belief but to work with them to help them be as healthy as possible. If their beliefs are dangerous or make successful treatment impossible, it is appropriate to share your concerns and seek a compromise. Doing so in a respectful way is more likely to succeed than being argumentative, condescending, or patronising.

WORKING WITH EACH OTHER, NOT AGAINST EACH OTHER

A case study about traditional medicine

Mr Apa is a 19-year-old Samoan man who is losing his vision. He has had two operations, but his loss of sight continues to progress. After his second operation, his mother contacted a Taulasea (traditional healer) and insisted that Mr Apa consult him. Knowing that the Taulasea would apply different formulations not only to his eyes, but to his ears as well, Mr Apa asked his specialist, Dr O'Connor, for his opinion.

At first, Dr O'Connor was taken aback, assuming that Mr Apa was seeing the Taulasea because he had lost faith in Dr O'Connor's skill. He was tempted to point out that the traditional remedies were not based on any kind of evidence, that the formulations were not made to any kind of quality standard, and that it was possible that the substances would interact negatively with the eye drops he had prescribed for Mr Apa. However, before he shared these concerns, Dr O'Connor asked Mr Apa about the role of Taulasea and how they had helped him and his family in the past.

Mr Apa replied, 'Well, Doc, I'm not sure I believe that they'll work, but my mother really does. And besides, you see loads of advertisements for herbs and supplements these days and at least the Taulasea's remedies have been used in Samoa for generations. Like I say, my mum really believes in the traditional medicines, and she worries that my not trying them is part of the problem. She doesn't mind my using Western medicine too, but she thinks the two systems can work together to save my eyes. She says that I walk in both worlds, so treatments from both worlds should be used to help me. Plus, it's really important that I see the Taulasea for my mother's sake – so that she is seen by the community and the rest of our family to have tried everything for me. Our community might think she isn't taking good care of me if we don't try every cure available.'

Pleased to learn that Mr Apa has not lost faith in him and that in fact he feels comfortable enough to share his fears and concerns, Dr O'Connor explains, 'Well, Mr Apa, I can certainly understand how you feel. I have relatives who rely on treatments that aren't based in Western medicine either, and they, like your mother, feel they get good results with them. I think it's fine that you see a Taulasea – if it were my vision, I'd want to be sure that I wasn't overlooking anything either. I do have a few concerns, though. Some natural substances have the potential to interact with Western medicines, and I want to be sure I'm not giving you anything that would react badly to the traditional medicine, and that your healer isn't giving you anything that might react badly with what I give you. If you can make sure that we each know what the other person is doing, then I think there will be no problem with you seeing both of us.'

Summary points – traditional Pacific health beliefs

- Ancient Pacific beliefs attributed illness to supernatural forces rather than biological agents. Pacific peoples may feel responsible for their illness/injury and/or may consider that a stigma is attached to their condition.
- Massage is a common Pacific medical treatment; another is plant-based remedies.
- Never belittle a person's traditions or concepts of health. Work with the patient and family on the best way to use both modern Western and Pacific medicines to help the patient.

Special Issues



Maternal and child health

There are a wide range of issues that relate to maternal and child health among Pacific peoples. As we only have space to summarise these issues in this resource, the following is a list (with recommended article information) of issues you might consider when dealing with Pacific maternal and child health:

- Pregnancy planning ⁴²
- Maternal smoking ¹³
- Breastfeeding ¹⁰
- Sudden Infant Death Syndrome ⁴¹
- Non-immunisation of Pacific infants ⁴³
- Diabetes in young Pacific peoples. ^{49,64}

Care of older and disabled people

Pacific peoples generally prefer family to care for older people or disabled family members, even if community support services are available. One reason for this is that Pacific peoples are often uncomfortable sharing problems outside the family. Within Pacific communities, disability and ill health may be attributed to a curse or be seen as evidence of sin. Because of this belief, individuals and families may be ashamed of illness or disability and want to keep these issues very private. Pacific peoples also often lack confidence in home care services because they do not understand them well.

This means that many Pacific families try to provide care independent of any support agencies. Unfortunately, traditional patterns of care for older Pacific people may be under pressure because of demography and employment demands. This can cause extreme stress for family members trying to provide caregiver services, as well as a lower quality of life for the patient. By developing an open and respectful relationship, you will be able to help the family and patient to understand the options available to them, and perhaps to encourage them to make use of helpful services.

Gender issues

While some broad generalisations can be made about gender, the diversity of Pacific nations and peoples makes it is critical to approach each patient with an open mind and to ask about their own circumstances and preferences.

Traditionally, men were expected to provide food, shelter and protection for their family. Female roles revolved around reproductive capacity and care of the family. While tradition does not define modern reality, it continues to influence the roles of males and females today.

Gender identity issues

In many Pacific societies, there are people who adopt certain characteristics of the opposite gender (transgenderism). In ancient Polynesia, and particularly in Samoa and Tonga, gender was a secondary principle in ascribing social rank.⁵⁹ In Samoa, for example, a 'fa'afafine' may be physically male, but considered feminine. With the

centre of Samoan life being family, rather than self (and thus gender), the acceptance shown towards fa'afafine in modern society should be no surprise. In Tahiti the equivalent of fa'afafine is 'mahu', while Tongan people use the term 'fakaleiti'. Some transgender patients may be reluctant to have genital examinations and it is essential to use a non-judgemental approach.

Although men with feminine characteristics and behaviour have been accepted historically, homosexuality and lesbianism are at best ignored or at worst formally disapproved of in Pacific societies, mostly because of the widespread influence and teachings of Christianity.

Addiction

Addiction issues for Pacific peoples are similar to those of the general population.

Alcohol is the number one drug of choice, with cannabis becoming more popular amongst the younger generations. Methamphetamine use is increasing, but is not as common because it costs more than alcohol and cannabis. Problem gambling is an issue for some Pacific peoples.

Pacific peoples are more likely to face barriers to treatment than other ethnic groups in New Zealand. Language barriers and the shame of 'having a problem' may prevent Pacific peoples from accessing effective treatment.

Pain and palliation

Studies of pain behaviours across cultures emphasise the need to be wary of cultural or ethnic stereotypes. While there are general cultural differences, it is always important to assess each person individually. Many Pacific peoples will not be confident to speak out about their pain. Because Pacific peoples traditionally respect those with higher status, such as healers and doctors, they may answer a practitioner's questions with a simple yes or no, or may avoid the issue for fear of 'wasting the doctor's time'. This can prevent you from fully understanding the patient's issues, unless you make an extra effort to inquire about any concerns.

Using open-ended questions may be helpful, as well as specific questions on how pain or disability is affecting daily activities. As Pacific peoples use painkillers are less often, they may be reluctant to ask for analgesia, even when they desire it. Therefore, health practitioners need to build a strong bond with Pacific patients to provide them with appropriate care.

Hospital-specific issues

Many Pacific peoples are reluctant to go to hospital, partly because they consider hospitals 'places where people die'. Since hospitals do not place the same spiritual significance on death, the hospital rooms and beds may not be properly cleansed (by Pacific peoples' standards), creating worry or discomfort for Pacific patients. Pacific peoples are also used to being surrounded by friends and relations, particularly when they are ill. Hospitals that place restrictions on the visitor hours and numbers can make the unpleasantness of a hospital stay even worse. If it is necessary to restrict visitors, be sure to explain the reasons to both the patient and their family, and work to find a compromise.

Hospitals in larger centres such as Auckland and Wellington have Pacific cultural support teams as well as access to interpreters. Clear protocols for working with these teams can help you greatly in your dealings with Pacific patients and their families. These hospitals also provide Pacific cultural awareness training; taking part in this training, as well as having a collaborative approach to the cultural support teams, can help doctors to communicate more effectively with patients and families in the hospital setting.

Sexual health

Sexual health is an issue for Pacific peoples, as it is for other ethnic groups in New Zealand. However, some issues are more common within Pacific communities. For example, young Pacific peoples are influenced to a greater degree by the wider population, which translates to a higher rate of casual sex for the younger generation than their elders experienced.

Young Pacific peoples who contract a sexually transmitted disease are often not confident to tell their family. This creates a gap, and young people may not know what to do. Rates of chlamydia and gonorrhoea have increased significantly in the past few years in New Zealand, and the rates of both diseases are disproportionately high in the Pacific community.

Sexual health is one area where Pacific patients (particularly young people) may well prefer to see a non-Pacific provider. It is likely that they will want to discuss sexual health issues without family members present. Young women may feel more comfortable discussing these topics with female clinicians, and young men may prefer male providers. The responsibility lies with the doctor to have the necessary communication skills to address sexual health in a comfortable manner.

Commenting about Pacific parents' religious and cultural preference for celibacy before marriage, will signal to a young patient that the doctor understands the conflicts that the patient may face being sexually active in a community that tends not to acknowledge this reality. This may empower the young person to make responsible decisions about their sexual activity.

CONFLICTING IDEAS

A case study about expectations

Dr McFarlane looks at her schedule. Her next patient is Ms Anna Tairi, a 16-year-old Cook Island woman, there for a sexual health check. She realises that this visit will require a totally confidential consultation, due to the questions she needs to ask about sexual practices and other sensitive topics.

When Anna arrives, her mother, Mrs Tairi is with her. Dr McFarlane greets them both and asks Anna why she's there, in case Mrs Tairi does not know that her daughter has requested contraception. Mrs Tairi answers, explaining that Anna is there for a sexual health check and birth control. She laughs when Dr McFarlane looks a bit surprised and explains that she and her daughter have talked openly and honestly about sexual health since Anna began her periods. Mrs Tairi is aware of how Anna's relationship is developing with her current boyfriend and she's glad that her daughter is behaving responsibly in taking care of her sexual health. She's there to support her daughter.

Dr McFarlane congratulates the mother and daughter on their close relationship and explains how she would like the consultation to go ahead. She also advises Mrs Tairi that she will ask her to leave the room during part of the consultation, but will then invite her back in.

Mrs Tairi nods agreeably and Anna looks happy as well. In this way, Dr McFarlane has made sure that she will have some time to speak with Anna privately and address any confidential issues, but she has not offended either woman by summarily evicting Mrs Tairi from the room.

Note: The need for a physical examination provides an opportunity to speak with the teenager without her family present. During this time, additional questions or those of a sensitive nature can be asked. Please also see the Council's guidelines on *When Another Person is Present during a Consultation and Sexual Boundaries in the Doctor-Patient Relationship: A Resource for Doctors*, both available online at <http://www.mcnz.org.nz>>>Publications

Care of youth and adolescents

The challenges faced by today's Pacific youth are very different from those of past generations. Young Pacific peoples find it increasingly difficult to balance the conflicting pressures and demands of traditional and modern cultures.

Many of today's young people find it hard to cope with contradictory peer and parental advice. Increasing numbers of young people do not receive adequate emotional support from families or communities, because families and traditional community structures have broken down. Within and outside the school system, adolescents have limited opportunities to develop their leadership skills and to realise their right to participate.⁶⁵ Problems, including alarming rising rates of juvenile crime and adolescent high-risk sexual behaviour, are related to these complex issues.

Pacific youth are also exposed to risk factors such as increasing urbanisation and decreasing consumption of local foods. Obesity is emerging as a problem among adolescents. This is mainly due to high fat diets, the accessibility of fast food, lack of exercise and a more inactive lifestyle.

Emerging issues

The spiritual sacredness of the person in Pacific culture means that emerging issues such as organ donation^{23,46} and DNA collection are particularly sensitive. The best way to approach these issues is, as always, to communicate openly and respectfully. Rather than avoiding certain topics based on so-called conventional wisdom (for example, 'Pacific peoples don't donate organs'), it is always better to ask each patient and family what they prefer and feel.

Death and dying

While each Pacific culture has its own experiences of death and dying, there are some similarities between cultures.

These experiences are similar to those outlined for Māori in the Council's *Best Health Outcomes for Māori: Practice Implications*.

Death and dying are stressful times in any culture, and every culture has its own rituals. Some ceremonies are more complex than others, and most, when unfamiliar, can seem odd or intimidating. For Pacific peoples, death and dying have deep cultural significance, and it is not uncommon for Pacific peoples who are otherwise relatively unobservant of tradition, to follow very traditional practices when they or their loved ones are near death.

The communal nature of Pacific society is particularly apparent at these times, with family members travelling to visit and stay with the patient. A medical team's ignorance of Pacific practices could unintentionally make a difficult time for the family harder, for example by interfering with the family's need to see and speak to the deceased.

It is particularly important for the family to understand the patient's medical needs during the process of dying, and the intensity of support needed to ensure the patient is able to die with dignity and in comfort. Anecdotally, doctors do not always refer Pacific people to hospice or palliative care services when they should. This creates a gap between the family's preference that the patient die at home, and the services available that can give the family the support necessary to care for the dying patient.

How doctors can help

It is particularly important that the family have familiar faces they can rely on when facing the death of a loved one. This is a time when Pacific families, like most others, may be very dependent upon their GP for help in understanding the medical environment. Even if the patient's care is mostly in the hands of specialists, the GP is likely to have the strongest relationship with the family, and should continue to be involved in the patient's care and in discussions with the family. Times like this can make or break your relationship with the family, and your continuing close involvement can do an enormous amount to ease their anxiety and suffering.

If you are familiar with the family's cultural preferences, or are comfortable asking about them, you can provide a much-needed bridge between them and other, less informed

medical staff. As with all cultural practices, do not allow your unfamiliarity or discomfort with talking about issues like dying, death, handling of remains, or funeral practices prevent you from helping your patient and their family. Ask respectful questions so that you can help the family work with the hospital to make the experience as positive and culturally appropriate as possible.

When old people are near to death, Pacific peoples may delay consultation until very late. This may be not because they do not care or because they misunderstand the condition's severity, but because the patient wishes you to confirm their belief that death is imminent. The patient may not be seeking, expecting, or even hoping for a cure, so do not feel that you must rush to 'undo the damage' caused by the late presentation. Be clear on what the patient and family's wishes and expectations are. Keep in mind that, whenever possible, many families will prefer to take a terminally ill patient home, rather than have them die in hospital.

Pacific mourning and funeral rites

Pacific mourning and funeral rites are important and complex. Whenever possible, it is best to ask the family spokesperson (or the patient) about their preferences. Pacific staff or knowledgeable community members may also be able to help determine the family's preferences. In nearly all Pacific families, a death will be a time for family and wider relations to gather together to perform the appropriate farewell customs. The farewell is likely to be held over several days. It may take place at the deceased person's home, a family member's home, a church or church hall.

If they are not present, the patient's family should be told immediately when a patient's death is imminent. The family will want to be with their relative and remain with them after death, so a private room should be provided. The family may wish to wash and dress the body themselves, so their preferences should be determined and, wherever possible, honoured. Try to allow the family enough time to grieve before moving the deceased. The family should be consulted as to how the deceased should be moved, as well as whether they wish to accompany him or her.

During the grieving process, the family will host all visitors at the place where the deceased is lying. This can be a huge human and financial undertaking, so be aware of this when dealing with the family of a seriously ill or dying patient. Some family members, for example, may be thinking about or planning for the grieving process when they ask you about the patient's prognosis or when the body can be released.

The more you can understand what they are thinking, the more help you can be to them at this critical time.

After death

It is important to note that the family may strongly resent delays in the grieving process. Explain any necessary delays and help the family work with the hospital to minimise these delays as much as possible. As Dr Durie notes: 'The doctor's duty does not end when the patient has died, but should continue until the body has been respectfully returned to the bereaved family.'¹⁷

After the formal grieving process and burial, there will usually be a substantial meal. An official period of mourning may be observed which could be anywhere from 3 months to 12 months. A headstone unveiling will often take place within 3 months to 2 years after the passing of the deceased. As the doctor, you may be invited to attend some of the ceremonies, but do not feel you must wait for an invitation. You will usually be most welcome.

As with all groups, Pacific peoples expect a complete and accurate explanation any time that a post-mortem is required, whether it is a coronial or non-coronial proceeding. Pacific peoples may wish to be present during the procedure, and the deceased should be released to the family as quickly as possible afterwards. Avoid cutting the deceased's hair whenever possible; if it is necessary, explain this to the family ahead of time. Any tissue, body parts or fluids taken during the autopsy should be handled sensitively; ask the family whether they would like the material returned, retained or disposed of.

- Alcohol remains the number one drug of choice in Pacific communities, as in many others.
- Make use of hospital-based Pacific cultural support teams if they are available in your area.
- For sexual health issues, many Pacific peoples may prefer to see a non-Pacific physician and may prefer not to have family present. Be sure to find out the individual's preferences.
- Death and dying are of deep cultural significance for Pacific people. It may help to discuss these issues with patients and families before a crisis occurs.
- Most Pacific families will want to remain with their relatives during and after death. They may wish to wash and dress the body themselves.

Summary points – special issues

- Pacific peoples, especially older people, may prefer be cared for by family members, even if community support services are available. Help your patients and families to understand their options and help them to negotiate the ideal blend of family and community support so that family members do not become extremely stressed or burnt out.
- Although transgenderism exists in many Pacific societies, homosexuality and lesbianism are often ignored or denounced.

Summary



Promoting good health has been defined as the process of enabling people to control and improve their health, not by changing their beliefs or values, but by helping and encouraging them to determine their own good health and wellbeing.³¹

For Pacific peoples, promoting good health involves assisting the communities to make the right choices to enhance and maintain health.³¹ However, Pacific communities can only actively work to improve health if the necessary resources – including doctors – are accessible, available, acceptable, and culturally appropriate.³¹

As for other cultures, most Pacific peoples think it important to establish trusting relationships with their health-care providers. If providers and patients understand each other, patients are more likely to be satisfied and to accept treatment. Knowing different Pacific traditions will increase your cultural competence, and help you to communicate better with Pacific patients. In turn, this will encourage patients to seek care more promptly, will improve the collection of clinical information, will help providers to understand their Pacific clients, and will help Pacific clients and their providers to communicate better.

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