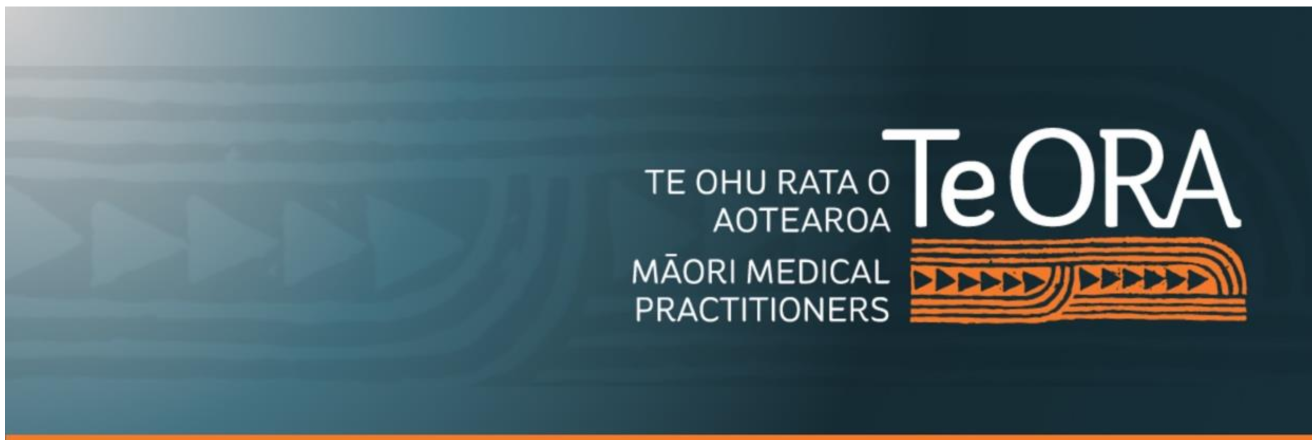

Feedback on Draft Medical Council of New Zealand (MCNZ) statement on Cultural Competence and Cultural Safety

Te Ohu Rata o Aotearoa (Te ORA)

22nd March 2026

1. Te Ohu Rata o Aotearoa (Te ORA) is the Māori Medical Practitioners Association consisting of 345 doctor members, including 17 associate (non-Māori) members, and a further 163 Māori medical students. Te ORA represents a large portion of the Māori medical workforce. Te ORA's vision is to provide Māori medical leadership to the health sector to effect Māori health development.

2. Te ORA notes that both cultural competency and cultural safety are crticially important for doctors, and we support the Medical Council of New Zealand (MCNZ) in seeking to provide clear guidance around the specific competencies required for medical pratictioners. Eliminating health inequities existing along cultural dimensions, including ethnicity and Indigenous status,[1] requires culturally-competent and culturally-safe health workforces and systems [2,3]. The MCNZ should and must align to evidenced based best practice which includes the requirements for doctors to be both culturally-competent and culturally-safe in their practice.

3. However, Te ORA does not consider that the draft statement provides the much-needed clarity regarding the distinction between cultural competency and cultural safety, and we note that the statement misses important aspects of cultural safety in particular.

4. We believe that cultural competency and cultural safety needs to be separated into separate statements. There is confusion/blurring between these two concepts and having these concepts clearly articulated is supported by the provision of separate statements. We note that in practice, doctors tend towards obtaining cultural competenacy about "other" cultures rather than doing the hard work of critically examining themselves and their own culture for bias and discrimination and the impact that this may be having on their medical practice.[4] We believe there are risks associated with medical professionals avoiding the work required to develop the critical consciousness competencies of cultural safety and a clear separation of these concepts is needed.

5. The cultural safety defintion in this statement is incomplete and weakened compared to the 2019 MCNZ defintion and importantly, removes mention of power and priviledge. Te ORA supports the

defintion of cultural safety as *"Cultural safety requires doctors to examine themselves and the potential impact of their own identities and culture on the practice of medicine. Culturally safe doctors acknowledge and address their own power, privilege, biases, attitudes, assumptions, stereotypes, prejudices, and characteristics that may affect the quality of care provided. Cultural safety requires a critical consciousness where doctors engage in ongoing self reflection and hold themselves accountable for culturally-safe medical practice, as defined by patients and their communities, and as measured through progress towards achieving health equity. Culturally-safe doctors influence healthcare to reduce bias and achieve equity within the workforce and working environment."*

6. A key problem with the definition in the draft statement is the omission of power/privilege. Cultural safety is not achieved through doctors simply reflecting on their "views and biases". Cultural safety is inherently connected with how power and privilege are distributed along cultural lines – the MCNZ must require doctors to understand how their own dimensions of power, privilege or marginalisation impact on cultural safety and this needs to be reinstated to the definition.

7. Cultural safety in the definition in the draft statement is restricted to the individual clinical encounter, which is not accurate. Medical practitioners have a direct role in contributing to cultural safety health systems, services and care in the full scope of their practice – including their contribution to the organisation/leadership of health services, workplaces, and training.

8. The draft statement mixes cultural competency and cultural safety throughout, so contributes to further confusion and interchangeability between these two distinct, mutually reinforcing concepts.

9. The draft statement lacks specificity about the competencies and behaviours required from doctors, and fails to provide clarity regarding how doctors can acquire and assess their cultural competency and cultural safety.

10. Terminology has been introduced which Te ORA does not support – including the use of the term "underpriviledged" in place of marginalisation/oppression.

11. We note that a number of Te ORA members are experts in the defining and framing of the concepts of cultural competency and cultural safety within an Aotearoa New Zealand context.[4,5] We would encourage the MCNZ to prioritise this expertise and the published literature and evidence base in its process of content review for these statements.

12. And finally, Te ORA wishes to acknowledge our tuakana Dr Rachelle Love for her leadership of the MCNZ at this time. We are aware that she is being personally targeted (negatively) for the MCNZ putting these statements into public. We are shocked and concerned that this is occurring to one of our own members and believe that this is further evidence that the requirement for cultural safety and cultural competency for medical practitioners and our sociey as a whole remains necessary.

References

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3. Browne AJ, Varcoe CM, Wong ST, et al. Closing the health equity gap: evidence-based strategies for primary health care organizations. *International Journal for Equity in Health* 2012; **11**(1): 59.
4. Curtis E, Loring B, Jones R, et al. Refining the definitions of cultural safety, cultural competency and Indigenous health: lessons from Aotearoa New Zealand. *International Journal for Equity in Health* 2025; 24(1): 1-10.

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