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Rethinking the consultation in 21st century Aotearoa New Zealand

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The successful practice of medicine requires practitioners to use a model of the consultation that goes beyond biomedicine. For many of us who trained as a general practitioners (GPs) in the Anglosphere in the late 20th century, Pendleton's patient-centred model of the consultation[1] with its seven sequential tasks of the consultation (starting with the first: to establish the patient's reasons for attending) became hard wired in our practice during vocational training. We then encountered a further development of this model, the Cambridge-Calgary model,[2] with its explicit incorporation of a biopsychosocial approach, as we ourselves went onto teach GP registrars and medical students communication skills. There is no doubt that using these models has helped us become better doctors, and hopefully benefitted our patients too. But what is the continuing relevance and utility of such Eurocentric models when practising medicine in the culturally diverse context of 21st century Aotearoa New Zealand (NZ)?

In this issue of the *Journal of Primary Health Care* our guest editorial from Kyle Eggleton and Lucy O'Hagan, two Pākehā GPs, explores this question through a consideration of how we might embed cultural safety[3] into currently used consultation models in NZ.[4] This is an important question, as there is good evidence that culturally safe consultations can deliver a good patient experience, increase trust, reduce health inequities and improve health outcomes for Māori.[5] Eggleton and O'Hagan highlight that Hauora Māori models such as the Indigenous Health Framework (Hui process and the Mehana model) provide a framework to deliver culturally safe consultations *and* that the successful use of these models relies on practitioners having the consultation skills provided by the Cambridge-Calgary model. Drawing on the work of Donald Schön[6] they argue, however, that what is missing from consultation models such as the Cambridge-Calgary model is the concept of critical self-reflection. This is a major problem, as culturally safe practice is accomplished through a process of critical reflection by the practitioner on their own culture, biases and the power asymmetry of the consultation.[7] Without critical self-reflection, when reflection on action becomes reflection in action in the consultation,[6] culturally safe practice risks being more rhetoric than reality.[4]

Māori and Pacific health and cross-cultural health care feature prominently in this issue. Rheumatic fever (RF) and gout are both important diseases which inequitably affect Māori and Pacific people. Tu'akoi and colleagues,[8] in their scoping review of interventions and initiatives seeking to prevent group A streptococcus infection and RF in NZ found no long-term reduction in RF over time. Samuela Ofanoa and colleagues[9] also conducted a scoping review, looking at interventions to improve the uptake/management of allopurinol for gout in NZ. They conclude that the reviewed interventions did not sustain retention, completion, and engagement for Māori and Pacific people. Both reviews emphasise the need for better targeted interventions involving co-design with affected communities. In a viewpoint article one of the co-authors of both these reviews, Malakai Ofanoa, reflects on the strong value placed on education in Pacific culture and tells the story of how it shaped his and his family's achievements.[10] Moving onto cross-cultural health care, Faulkner and Moir explored, using an online survey, NZ nurses' confidence in using a standard screening questionnaire for postnatal depression (PHQ-3) across different ethnic groups.[11] They found that nurses lacked confidence in the use of the PHQ-3 with ethnically diverse families. Asians are the third largest population group in NZ (15%) and have lower rates of enrolment in general practice using screening services. Xiang and colleagues,[12] using qualitative methods, found an important barrier to their accessing

health care was a lack of relevant and reliable information to facilitate navigation of the NZ health system.

Rural health also has a strong focus in this issue. Whitehead and colleagues[13] provide a standardised method for describing each rural hospital's catchment boundary. They found considerable heterogeneity in the populations served by rural hospitals. Miller and colleagues[14] estimate the costs associated with assessing patients with low-risk chest pain using the rural accelerated chest pain pathway (RACPP) in rural general practice compared with transporting such patients to an emergency department that may be many kilometres away. They conclude that there are likely significant savings if the RACPP is used to assess patients with low-risk chest pain in rural NZ general practice. Darlow and colleagues[15] consider whether or not short rural interprofessional educational programmes as an undergraduate can influence healthcare graduate career choices. They found that, at 3 years post-registration, there was no measurable impact on rural or community workforce participation. Lastly, O'Hagan lived and worked as a GP in the same small rural town for 20 years, and in a viewpoint[16] reflects on the challenges this causes for the boundaries between professional and personal spaces and how these can be best managed, for doctor and for patient, over time.

Older people's health also features in this issue. Retirement villages are on the increase and Yoshihara and colleagues[17] explored the characteristics of the physical activity undertaken by residents. Bowls/pétanque, exercise classes and walking were the mostly commonly undertaken activities. Polypharmacy is also more common in older adults, though not all polypharmacy is harmful. Liu and Harrison[18] sought to develop a set of NZ-specific potentially inappropriate medication indicators which should trigger a formal medication review. Using formal consensus techniques they identified 61 indicators across a wide range of therapeutic groups.

Two papers address how we can achieve better working across the NZ health system. General practitioners with special interest (GPwSI) are increasingly used to provide 'specialist' services and Brundell and colleagues[19] show that otolaryngology patients can be suitably managed by a GPwSI. A leader in integrated care in NZ was the Canterbury health system, with its HealthPathways platform now being widely used by medical practitioners across NZ and internationally. Eden and McGeogh,[20] in an improving performance report, describe the implementation and monitoring of Allied Healthways, a website for allied health professionals. As with HealthPathways, the key value of Allied Healthways was on the local clinical conversations facilitated during pathway development. This issue concludes with a *Cochrane Corner* on whether behavioural interventions can reduce aggressive behaviour in people with intellectual disabilities,[21] and *Charms and Harms* considers Garcinia, an edible fruit which is claimed to have weight-loss properties.[22]

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Conflicts of interest. Tim Stokes and Felicity Goodyear-Smith are Editors in Chief of the Journal of Primary Health Care.

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