Part 2 – Reflections on wellbeing, racism and health equality

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In this podcast, Jules Willcocks chats to Dr Hinemoa Elder about her reflections on wellbeing, racism and health equality in our healthcare systems.

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About Dr Hinemoa Elder

Hinemoa Elder Ngāti Kurī, Te Rarawa, Te Aupōuri and Ngāpuhi. MBChB, FRANZCP, PhD, MNZM, is a New Zealand child and adolescent psychiatrist and fellow of the Royal Australian and New Zealand College of Psychiatrists. She works at Starship Children's Hospital in Auckland. She is a deputy psychiatry member of the NZ Mental Health Review Tribunal. She has a PhD in Public Health (2012) in which she developed tools for Māori whānau (extended families) with Traumatic Brain Injury and was also the recipient of a Health Research Council of NZ Eru Pomare Post Doctoral Fellowship. The approaches she developed are used in rehabilitation in the community. She continues to work in TBI and dementia research. She received the MNZM for services to Māori and to Psychiatry in 2019. She is an invited member of the Busara Circle, a group of senior international women leaders which forms a critical support for the Homeward Bound project, a global leadership programme for women in science, of which she is an alumni, travelling to Antarctica with the project in 2019. Dr Elder is a Board member of The Helen Clark Foundation, a non-profit, non-partisan public policy think tank which generates public policy research and debate. She is a board member of the RANZCP Foundation. Dr Elder is the Patron of 'Share my Super" a charity aimed at ending child poverty in NZ. Dr Elder has written two best-selling books published by Penguin Random House. "Aroha. Māori wisdom for a contented life lived in harmony with our planet', was named on the Oprah Winfrey Book club in 2021. 'Wawata. Daily wisdom guided by Hina the Māori moon, is currently the number one best selling non-fiction book in NZ. Dr Elder is also regularly invited to give keynote presentations. She was an invited speaker to the Rhodes Healthcare Forum, Oxford University in 2019. Hinemoa has a background in theatre and dance. She performed in a NZ play at the Edinburgh Festival, Assembly Rooms in 1986. She is a past Chair of Auckland Theatre Company Trust and the inaugural Chair of Te Taumata a Iwi The Arts Foundation. Hinemoa also worked in NZ childrens' television in the early 1990s.

About Dr Jules Willcocks

Jules Willcocks is an Emergency Medicine Consultant, the Co-Director of Emergency Medicine Training and the Co-Director of Prevocational Education and Training in Alice Springs Hospital. He is the Deputy Censor for the NT for ACEM and sits on the Specialist Training and Assessment Committee and the Council for Advocacy, Practice and Partnerships at ACEM.
He is interested in bringing out the best in people principally through mentoring and coaching. He firmly believes that wellbeing is a crucial part of this and that you cannot look after someone to the best of your abilities if you yourself are not well.He trained as an executive coach and has a particular interest in the role of personal psychology and how this interfaces with our performance in exams and at work as well as in general day to day living and how all of these tie in to our general wellbeing.

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With Dr Hinemoa Elder and Dr Jules Willcocks

Introduction

In this podcast we hear from Dr Hinemoa Elder, a New Zealand child and adolescent forensic psychiatrist and author of *Maea te Toi Ora: Māori Health Transformations*, *Aroha* and *Wawata – Moon Dreaming*. She is a professor in indigenous research at Te Whare Wānanga o Awanuiārangi. This podcast is sponsored by Global Medics.

– 1. What is your perspective on the health inequalities that are a significant issue in our workplace?

- A recent report states that despite advances to medical care, Māori patients in New Zealand are referred less for tests and treatments and health outcomes are significantly worse
- Thirty years ago, a number of doctors would come to Aotearoa New Zealand to see children with acute Rheumatic fever and Rheumatic heart disease – cases that were not seen in the UK, US or Germany
- However, today we continue to have 40-80x more Rheumatic heart disease in Māori and Pacific children than the non-Māori non-Pacific community
- This is in part due to racist contracting which is a barrier to change. There is an illness of poor crowding, poor housing, overcrowding and poverty
- There is abundant research about this condition but there is no robust mechanism to provide strategies to make a difference to these children's lives
- The same applies for Māori and non-Māori children who are treated under compulsory treatment orders

2. There are many ways in which racism plays out in healthcare systems. Can you please expand on this?

- There is a large body of literature from around the world that articulates clearly the healthcare user experience of racism, the teams experience and the importance of anti-racist training
- We also know that there is a lack of organisational support in managing racism
- In general, there is a racial bias that healthcare systems tend to think about healthcare as impartial, so we don't always discuss racism in the workforce
- New Zealand has had a major restructure of its health system which began mid last year
- We have a Māori health authority called Te Aka Whai Ora and this is a key structural element to leading and monitoring this transformational change that is needed to create a difference for Indigenous peoples – Indigenising healthcare
- There are covert messages across healthcare for our Māori patients that say we are only interested in your symptoms and not who you are as an individual
- A narrow, biological approach is not the way contemporary medicine is to be practiced

3. How can we best address the biases that are prevalent in delivering healthcare?

- We need to listen with well-informed ears, ears that have been informed of the history of the original people of this land; listening is an underrated skill
- A missing piece in medical education is the historical politics of the land where we work
- Doctors that come to work in Aotearoa New Zealand must be informed about the history of colonisation and how that has impacted patients
    - This must then be applied on a daily basis – knowledge that isn't merely of theoretical basis but must be operationalised
- Another issue is gender difference
    - Female doctors face significant discrimination; 50% of female medical students have been sexually harassed by the time they finish their medical training
    - Female doctors have also been shown to more likely adhere to clinical guidelines, promote preventative care, use more patient-centred communication and provide more psycho-social counselling
    - A JAMA paper looked at more than a million hospitalisations and 30 day mortality and re-admission rates were much better for those patients who had female doctors
    - There are many layers of discrimination for female doctors, including promotion, pregnancy, and they are much less likely to receive positive feedback and be described with superlatives than their male

counterpart; yet there is the evidence that female doctors are actually getting better outcomes

4. How can we change a toxic culture and overcome gender bias?

- I am interested in pursuing why are our male colleagues not standing up for us more?
- There was a review in the BMJ last year of 425 consultants, GPs, SMOs looking at male doctors' perceptions of sexism
    - There was half and half female to male ratio
    - What was found was that male doctors were overestimating the representation of female doctors across a range of specialty areas; this overestimation predicted the fact that they were less willing to support gender-based initiatives
- This presents an opportunity in that male colleagues need education to know that they are likely to have the bias that there is no problem with gender disparity
- We also know that female doctors get paid less than male doctors
- My perspective is that our male colleagues don't perceive themselves as sexist and want to be good allies but don't have the information
- We need to make it socially unacceptable for male colleagues to discrimination against females because they will have the evidence and will have practice-based evidence of how brilliant their female colleagues are to work with
- This can help to get rid of toxic, biased way of thinking about female representation the the betterment of our patients
- One of the areas I have been interested in is online misogyny
    - Recently New Zealand's prime minister resigned in part due to the exposure to toxicity
    - There has also been a senior Scottish politician who has stood down
    - There is much research that women in public life/ women in general still face online vitriol that is targeted at females
    - My question is what is stopping our male colleagues or male politicians from standing up to how unacceptable this is and preventing this

5. A question from Dr Elder to Dr Willcocks is what are the barriers to men themselves preventing misogyny?

- It needs to start at a very young age with education and role modelling – there is a lack of this in society
- Domestic violence rates in Australia are appalling – 1 woman is killed every week and for Indigenous women this is worse – this can be related to the effect of colonisation and past trauma as well as the ongoing issue of poverty and loss of culture

- The key is education and this has a long way to go, a similar principle applies to racism and the theme of threat when there is an individual outside of your group – they are afraid
    - Therefore the basis could be a sense of threat and education is a way forward
- Empathy and kindness is an important principle of inclusion
- There are covert societal norms that must be overcome and this will take time

6. As you have been able to embrace your Māori heritage more have you become more aware of covert racist structures?

- Yes. Racism and white privilege is ubiquitous and the fact that many white people don't see this is evidence – it is designed so that many white people don't see their privilege
- Difficult conversations regarding race can be accompanied by lots of sensitivity even among those who are well-equipped – the signalling is that you can't really talk about it
- Doctors have a responsibility to be sensitive to race – we are advocates for the most vulnerable people in society
    - We have licence to stand up for those people who don't have the voice we have
    - We must understand the literature about racism and the experience of racism of our patients
- We must find ways in which we can feel confident and comfortable to talk about racism at work
    - There are no go zones which is the way racism perpetuates
- Doctors have a particular role in recognising the damage to the whole being – the cultural, biopsychosocial and historical being – that racism implicates

7. We enter medicine to help people however it is difficult when there are governmental/ historical structures that perpetuates inequalities. What is your view on this?

- Succession planning needs attention and strategy to secure, for example, the opportunity for Māori students who may want to do medicine but get reminded all the time that this is NOT an option for you
    - Research shows that our children in school are given the message that this is not an aspiration that they should have – that other kinds of careers should be considered – not medicine, law or science which is unacceptable

- We are looking for a multiplicity of ways to make medicine a healthy career and a career we can maintain as Indigenous women
    - We must create safe spaces in the healthcare system for the young coming through to study medicine

8. Do you have any advice going forward for females/ males/ Indigenous people to change these outcomes? How can we make a difference?

- thThere is saying by a Māori King that states when a reed grows by itself it can be broken easily, but when it grows in a group it is indestructible
- Women in medicine have to stick together – we have to find common ground – we are diverse with a range of ages and stages as well as experiences of being women yet we have to find common ground to abolish the structures that perpetuate discrimination against us
- *Advice for men*: First clear the weeds, then plant
    - Weeding the mind of its thoughts no longer fit for practice
    - Our male colleagues need to look at the evidence and their own biases for opportunities to support women – we are not well represented and tend to be discriminated against, facing a significant amount of sexual harassment – be part of the solution and not the problem
- *Indigenous doctors and medical students*: A famous saying goes is: I am a sea, I can never be lost, blown by the winds, I have a reason for being
    - You are never alone, we have a powerful, ancient bond and we are here for each other
    - We need more Indigenous doctors, not less, find the people who can help you to stay on your precious track

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