



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

Best health outcomes for Māori: Practice implications

Acknowledgements

Best Health Outcomes of Māori: Practice Implications

This resource booklet has been prepared by Māuri Ora Associates for the Medical Council of New Zealand. The Council would like to formally acknowledge the contribution of Prof Mason Durie, Dr Paratene Ngata, Dr James Te Whare – all of whom reviewed the draft material, and the Māuri Ora Associates team. To the many other people who have contributed to this booklet, thank you.

Please check for updates to this document after December 2008.

Contents

INTRODUCTION	03
BACKGROUND EVIDENCE	04
Māori history and the Treaty of Waitangi	04
The Treaty of Waitangi and health	06
Māori health	06
Health inequalities	07
DIFFERENTIAL APPROACHES TO TREATMENT	08
CULTURAL COMPETENCE AND CLINICAL COMPETENCE	09
THE IMPACT OF CULTURE ON HEALTH	10
KEY MĀORI CONCEPTS	11
PRINCIPLES OF CULTURALLY COMPETENT CARE FOR MĀORI	14
Māori community involvement	14
Ethnicity data collection and use	15
The central place of effective communications	16
Guidance on Māori preferences	17
i. Māori pronunciation and communication	17
ii. Family/whānau support	19
iii. Initial contacts and protocols	19
iv. Examining patients	20
v. Physical contact	21
vi. Body language	21
vii. Sharing information and consent	22
viii. Traditional medicine/Rongoa	22
ix. Karakia and use of cultural experts	23
x. Special issues	23
1. Surgery	23
2. Anaesthesia	24
3. Mental health	24
4. Pain	25
5. Hospitals	25
6. Mate Māori	25
xi. Death and dying	26
xii. Autopsies	28
CASE STUDIES	30
SUMMARY	39
GLOSSARY OF MĀORI WORDS	40
REFERENCES	42

Introduction

This resource booklet is designed to assist branch advisory bodies and doctors in meeting cultural competence requirements of the Health Practitioners Competence Assurance Act 2003 (HPCAA), and to address the health inequalities affecting Māori. The booklet will complement the Medical Council of New Zealand (the Council)'s *Statement on best practices when providing care to Māori patients and their whānau*, and *Statement on cultural competence*.

The goal of this booklet is to help doctors to achieve greater awareness of the cultural diversity and the place of Māori in New Zealand, and to assist in incorporating cultural competence for Māori into continuing education activities, recertification and practice activities such as medical audits. The material provides both general guidance on Māori cultural preferences and specific examples around key issues. It is hoped that Māori specific cultural competencies will be developed in a framework of self-awareness so that doctors will be able to recognise their own values and attitudes, as well as the impact of these on their practices.

Since its signing in 1840, the Treaty of Waitangi has come to be considered a “statement of the individual and collective rights of Māori, the Crown’s responsibility to Māori, and a charter for New Zealand as a whole”.¹ The Treaty guarantees Māori equal access to national resources, and can be seen to require the government to ensure that Māori have “at

least the same level of health as non-Māori” (although this is demonstrably not the case).¹ The Treaty thus represents New Zealand’s long-standing, but as yet unrealised, goal to optimise Māori health, as well as the national commitment to the well-being of Māori people.*

The description of Māori culture in this booklet is necessarily generalised, and Māori patients, like those of all other populations, will have their own individual preferences and beliefs. Just as not every male patient likes to chat about sports during his examination and not every female patient worries about her weight, not every Māori patient will expect to say a blessing (karakia) before a medical procedure. It is up to the provider to learn the preferences of each patient, Māori or non-Māori, and to strive to put them at ease, in order to create and sustain a respectful, trusting therapeutic relationship.

The best way for a doctor to learn about Māori is by establishing relations with the following groups in their locality: iwi, Māori health care professionals, marae komiti, and other Māori organisations in their local areas. This booklet provides background information to make you more comfortable in broaching issues with these groups and individual patients, but no document can take the place of direct person-to-person contact as the best way to learn another’s culture.

*See Ministry of Health *Implementing the New Zealand Health Strategy* (Ministry of Health 2003), for further information on ‘Acknowledging the Special Relationship between Māori and the Crown under the Treaty of Waitangi’.

Background evidence

Māori history and the Treaty of Waitangi

According to traditional stories, Māori arrived in Aotearoa New Zealand from Hawaiki, and were well established by the fourteenth century. Māori adapted their east Polynesian cultural traditions to the land over at least 500 years before contact with European explorers.

After Captain Cook's exploration of New Zealand in the late eighteenth century, an increasing number of settlers came to New Zealand. In 1833, the British Government appointed James Busby as British Resident to protect British trading interests and counter the increasing lawlessness amongst traders and settlers. Despite Busby's presence, problems, including the number of dubious land sales, increased but the foreign population still continued to grow. By 1839, there were an estimated 2,000 Pākehā and 150,000 Māori living in New Zealand. In 1840, the British Government sent Captain William Hobson there as Lieutenant-Governor, with the express mission to sign a treaty with the native Māori chiefs. Hobson arrived with instructions from Lord Normanby from the Colonial Office to acquire sovereignty over New Zealand. His instructions included the recognition of New Zealand as a sovereign and independent state and went on in an almost apologetic way about the necessity of British intervention.

The Crown could make no claim on New Zealand without Māori agreement because Britain had earlier recognised Māori rights in a document signed in 1835 by 52 Māori chiefs at the instigation of James Busby. This document, the "Declaration of Independence", established the country

as an independent state and stated that all sovereign power and authority would reside in the hereditary chiefs and tribal leaders who asked Britain's King William IV to protect their nation from all attempts upon its independence.

Throughout this time New Zealand was still firmly under tribal control. The cultural framework of New Zealand in 1840 was still essentially Polynesian, and all European residents absorbed Māori values to some extent. Some Europeans were incorporated, however loosely, into a tribal structure, and the basic social divisions were tribal, not the European divisions of race, class or sect.² During this period, many Māori prospered: in 1857 the Bay of Plenty, Taupo and Rotorua Māori – about 8,000 people – had upwards of 3,000 acres of land in wheat, 300 acres in potatoes, nearly 2,000 acres in maize, and upwards of 1,000 acres of kumara. They owned nearly 100 horses, 200 head of cattle, 5,000 pigs, 4 water-power mills, and 96 ploughs, as well as 43 coastal vessels averaging nearly 20 tonnes each.³ There was also a strong desire by Māori to gain the literacy skills of the Europeans. Māori tribes encouraged missionaries to settle in their areas to acquire these skills. This not only gave them increased standing with other tribes, but opened up further trade with other Europeans.

A treaty was drawn up and, after a single day of debate, signed on February 6, 1840, at Waitangi in the Bay of Islands. Forty-three Northland chiefs signed the Treaty of Waitangi on that day, and over the next eight months, the Treaty was signed at more than 40 other locations. A total of 532 Māori chiefs signed, including some women, but

many important chiefs refused to sign the Treaty, including Te Wherowhero of Waikato, Taraia of Thames, Tupaea of Tauranga, Te Arawa of Rotorua and Te Heu Heu of Taupo.

The Treaty was translated into Māori by Henry Williams, an English missionary, prior to being debated at Waitangi. Both versions of the Treaty contain three Articles but the Māori translation differs significantly from the English version, resulting in two documents with words of different meaning and interpretation.

The first Article covers sovereignty. The English version states that Māori give up their “sovereignty” to the British Crown, describing it as a complete transference of power to the Crown. By contrast, the Māori version implies a sharing of power and uses the word “kawanatanga”, an improvised word which did not mean a transfer of authority from Māori to British hands, but implied the setting up of a government by the British. The nearest Māori equivalent to the English term would have been “mana” or “rangatiratanga”.

The second Article, mainly about the protection of property rights, also concerns “tino rangatiratanga” or chieftainship. The Māori version promises much broader rights for Māori in regard to possession of their existing properties. The English version specifically gives Māori control over their lands, forests, fisheries and other properties, but the Māori version implies possession and protection of cultural and social items such as language and villages. Explanations given at the Treaty signings support the conclusion that though the Māori expected the Treaty to initiate a new relationship

with the British, it would be one in which Māori and Pākehā would share authority. Māori were encouraged to believe that their rangatiratanga would be enhanced, not eroded, with the Queen or her representative having the power of governorship alongside their sovereignty as chiefs. Māori control over tribal matters would remain unchallenged.⁴

The third Article promises Māori the same citizenship rights as all British subjects.

Both versions of the Treaty of Waitangi are legitimate as both versions are signed. There is no reason to assign greater legitimacy to the Māori or the English version, and so both treaties – or both versions of the same treaty – may be considered New Zealand’s founding document. However, despite the promises and protection offered in the Treaty of Waitangi, the document was ignored in spirit and disregarded materially for many years. Many of the rights guaranteed to Māori were violated, and Māori lost most of their land through the nineteenth and twentieth centuries. The manner in which the land was lost was often questionable, and led to considerable protest from Māori over the years. Unfortunately, the protests fell on largely deaf ears until the establishment of the Waitangi Tribunal in 1975.

After the Treaty was signed, the non-Māori population of New Zealand continued to grow due to immigration from Great Britain, Germany, Scandinavia, Asia and southern Europe. With this influx, and as the Treaty’s provisions were increasingly ignored, the Māori population fell dramatically due to war, loss of land, and introduced diseases. In 1896,

the Māori population reached its lowest point, estimated at 42,000.⁵ During the twentieth century, the Māori population has recovered and at over half a million is now larger than ever before. However, social and economic disparities continue to exist.

In 1975, the New Zealand Government established the Waitangi Tribunal to rectify past breaches of the Treaty by the Crown (claims cannot be made against private organisations or individuals). The Tribunal considers both English and Māori versions of the Treaty when making decisions. If there is any ambiguity, the Tribunal is required to 'blend' the texts, but in any case is also instructed to have regard for the principles of the Treaty rather than the precise words. In this way, some of the difficulties of conflicting texts (English and Māori) can be avoided. Since its establishment, the Waitangi Tribunal has ruled on a number of claims brought by Māori, mainly by iwi (tribes). In many cases, compensation has been granted, often in the form of financial recompense, and vested in the tribe for economic development.

The Treaty of Waitangi and health

In its New Zealand Health Strategy, New Zealand Disability Strategy and Māori Health Strategy, the Royal Commission on Social Policy has identified three principles derived from the Treaty and relevant to Māori health.¹ The principles are Partnership (working with Māori communities at all levels to develop strategies for the community's health care),

Participation (involving Māori at all levels of the planning and delivery of healthcare services), and Protection ("working to ensure that Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values, and practices.")¹

The Treaty of Waitangi can be applied to Māori health in numerous ways. First, the Treaty should have ensured that Māori retained their land, forests and fisheries. Addressing land rights, loss of language and social disruption, compensation can help to alleviate some of the wider factors that impact on health. Further, in the Māori version, the Treaty ensures that "taonga", or precious possessions, would be protected and retained. In this context, health is sometimes considered a taonga. In addition, the New Zealand Public Health and Disability Act 2000 recognises the Treaty of Waitangi, by requiring district health boards to address Māori health and reduce health disparities by "improving the health outcomes of Māori and other population groups".

Māori health

Māori make up 14.7 percent of the New Zealand population (as at 2001), with every local authority area in the nation having a Māori population of at least 4.5 percent,⁶ yet Māori have the poorest health of any New Zealand group. This places enormous costs on society – both in terms of avoidable human suffering and financial expenses of lost work days and increased healthcare expenditures.

Māori have a higher mortality rate than non-Māori,^{7,8} as well as higher rates of illness.^{6,7,9-12} For example, excess cancer deaths among Māori account for two thirds of the excess male cancer deaths and one quarter of the excess female cancer deaths in New Zealand, compared to Australia.¹³

Māori infants die more frequently from SIDS and low birth weight than non-Māori children.¹⁴ Māori women have rates of breast, cervical, and lung cancer that are several times those of non-Māori women.¹⁴

These lower standards of health do not only lead to suboptimal outcomes for individual Māori. One Māori's negative experience may be shared with their whānau, influencing the entire community's perceptions and future behaviour.¹⁵⁻¹⁷ Negative experiences can also reinforce stereotypes within the practitioner community if a provider does not understand a Māori patient's dissatisfaction and thus cannot prevent similar experiences with other patients.¹⁸

Health inequalities

Māori have less access to medical care and rehabilitation services, and lower injury claim rates when compared with non-Māori.¹⁹⁻²³ Even though Māori turn up for GP appointments at the same rate as non-Māori, they obtain fewer diagnostic tests, less effective treatment plans,^{21,24} and are referred for secondary or tertiary procedures at significantly lower rates than non-Māori patients.²⁵

There is a higher incidence of obesity in the Māori community (27 percent vs 16 percent), which contributes to the higher incidence of diabetes (8 percent vs 3 percent, and the younger age at diagnosis (43 years vs 55 years).¹⁴ This is compounded by lower rates of diagnosis and lesser access to effective treatment.²⁴ Avoidable death rates are almost double for Māori than for other New Zealanders, and Māori die, on average, eight–ten years earlier.^{26,27} In summary, Māori are sicker, for longer periods, but have less access to care and die earlier than Pākehā.

These disparities in overall Māori health persist even when confounding factors such as poverty, education and location are eliminated, demonstrating that culture is an independent determinant of health status.^{21, 28}

Differential approaches to treatment

Studies have consistently demonstrated that some doctors treat Māori differently from non-Māori. Examples of this include the findings of the 2001–02 National Primary Medical Care Survey (NatMedCa). Of those patients diagnosed with chronic obstructive pulmonary disease (COPD), 71 percent of non-Māori patients were given a prescription compared to only 62.6 percent of Māori.²⁴ Another example is Arroll's findings that only 2 percent of Māori diagnosed with clinical depression were offered pharmaceutical intervention, compared with 45 percent of non-Māori patients with the same diagnosis.²⁹ Gribben also documented that Māori patients received fewer prescriptions and lab tests,²⁵ and Crengle et al observed that doctors spent 17 percent less time (2 minutes out of a 12 minute consultation) interviewing Māori than non-Māori patients.²⁴ Johnstone and Read's study demonstrated that some New Zealand practitioners hold completely unfounded beliefs about Māori, such as the idea that Māori are genetically more prone to psychosis and other serious mental illnesses.³⁰ McCreanor and Nairn reported similar unfounded beliefs in interviews with non-Māori GPs.³¹ The study documented high levels of

frustration among GPs due to their perceptions of Māori non-compliance and attempts to provide appropriate care through longer consultations with Māori patients. This is, however, at odds with the NatMedCa study, which collected data directly from GPs and found that Māori received significantly shorter consultations than Pākehā.³²

Analysis of the National Minimum Database over the period 1990–99 by Tukuitonga³³ suggests bias against Māori receiving cardiac revascularisation procedures even though the clinical need is much greater. Similar evidence of bias is available for outcomes following stroke,²² obstetric intervention,³⁴ heart failure,¹⁰ and asthma.¹¹

Cultural (mis)understanding and unconscious bias thus contribute to the state of Māori health. It is expected that improved integration of cultural and clinical competence should lead to better outcomes through improvements in communication, acceptability of treatment, adherence to treatment plans,^{6,35–37} and through measurements of doctor performance in delivery of services to Māori.

Cultural competence and clinical competence

Familiarity with patients' cultural heritage has been shown to be associated with improved patient care,¹⁸ thus rendering cultural competence "essential for high quality healthcare".³⁸ As a result, these aspects are now recognised as needing to be included in continuing education for healthcare professionals. The HPCAA requires all registration bodies, including the Council, to establish standards of clinical and cultural competence. In a series of articles in 2004, St George described how to establish and assess standards of competence in the healthcare setting,³⁹⁻⁴⁴ and many of these ideas are being incorporated into current recertification requirements. 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 for assessments of cultural competence alongside assessments of clinical competence within their recertification requirements.

The impact of culture on health

Providers should be aware of the specific cultural preferences of their patients, because – as described above – culture plays an important role in health. In the specific case of Māori patients, key issues need to be addressed so that the patient can achieve the best possible outcomes. These include:

- Acknowledging (and incorporating) the role of the broader whānau and other environmental factors in the patient's care
- Awareness of Māori belief systems, including views on individual mana, death and dying, reliance upon the family, prayer (karakia), and traditional healing practices and providers (tohunga), practices of tapu/noa, and communication styles
- Awareness of Māori lifestyles, including diet, non-work roles, and leisure time activities
- Learning about existing support mechanisms, such as kaiaatawhai, whānau, kaumātua, Māori practitioners, and other specialist service providers

In the Māori world view, there is a fundamental belief that understanding and being connected to the past are important for both the present and the future. This is demonstrated by the importance placed on tūpuna (ancestors) and whakapapa (genealogical connections over many generations). In addition, the importance of a healthy environment, which impacts both community and individuals, is incorporated into the world view of many Māori.

Māori values are often expressed as tikanga, which can also be thought of as a set of rules for living, which both support Māori social systems and reflect Māori knowledge and traditions. Specific concepts that doctors may come into contact with are:

- Tapu and noa – the concepts of risk and safety
- Mana – which relates to the importance of respecting individuals and their right to dignity
- Wairua – the spiritual force that exists within people
- Whānaungatanga – dealing with how important interpersonal relationships are to well-being

The principles of working with Māori patients and their whānau are easily generalisable to working with people from all cultures.⁴⁵ Doctors who recognise that Māori patients give a unique opportunity to learn about a diversity of Māori cultural values can translate this understanding to working with all patients and their families.⁴⁵

Key Māori concepts

The whānau is the basic unit of organisation of Māori society, with individualism being less of a focus and therefore less celebrated than in Pākehā society. For many Māori, one's role is defined by the whānau so that your contribution to your family defines who you are. 'Whānau' conveys a sense of responsibility, an interconnectedness, a system of interrelated obligations, responsibilities and benefits. Whānau members will feel strongly that they share in the achievements of their kin, and the whānau may even make decisions for a member, usually in consultation with the person concerned.

Māori are accustomed to making genealogical connections, and formal expressions of this connectedness are expected to be displayed at formal occasions, such as during a powhiri when they are used to make the genealogical connections between visitors (manuhiri) and the local people. Keep this in mind when meeting a Māori patient for the first time; sharing a bit of your own background and allowing them to do the same may make it much easier to establish a rapport.

A commonly held notion among non-Māori is that Māori women are of lower status than Māori men. In traditional Māori society, women held as much mana or authority as any male counterpart. This is in contrast to the traditional English concept where women were considered chattels of a male owner. The role and status of Māori women stems back to the Māori world view, Māori cosmology and essential tikanga notions, especially that of maintaining balance. Creation stories such as Papatuanuku (Earth

Mother), Hineahuone (first human formed from the earth – a female) and Hinenuitepo (Goddess of Death) highlight the importance and power of women. Another example of equal status among Māori men and women may be found in te reo Māori (the Māori language). Te reo Māori is gender neutral; for example there are no Māori equivalents for 'he' or 'she'. Also, words are used to refer to both parts of a female and other important things in society; for example whenua means both 'placenta' and 'land'. Many whare (buildings), hapū and iwi throughout Aotearoa New Zealand are named after prominent female ancestors. When dealing with Māori patients and their whānau, it is important not to assume that the male is head-figure. In Māori society one of the overarching principles is that of balance. Remember that men and women play complementary rather than opposing roles.

Other key concepts in Māori culture are 'tapu' and 'noa'. Tapu is most often described as a state of sacredness, but it also has the more general meaning of being special or restricted. Noa is the complementary state, the absence of tapu. It carries the meaning of being normal or ordinary or safe. The entire Māori world is divided into tapu and noa. For example, anything to do with death is tapu, while anything related to cooked food is noa.

Most objects or situations that are tapu indicate a probable risk to health. Communities learned to be cautious about tapu agents or places, and often a state of tapu was rendered noa after the risk had passed. A good example is the tapu that women have immediately after childbirth – a

way of reducing the risk of infection; or the tapu nature of a pataka (a storehouse for food) – a way of ensuring that food supplies will be protected and nutritional standards therefore maintained during winter. The application of tapu to parts of the body such as the head was also a warning to avoid unnecessary injury to the particular region or organ. Treating nesting birds as tapu was a way of increasing the potential number of birds for food, rather than risking the loss of a whole brood.

Many Māori feel that keeping tapu items separate from noa items is very important and find it distressing when the division is not observed. For example, in the case of a patient's death the whānau will likely wish to spend time in the room with their loved one. The presence of the dead body (tūpāpaku) makes the room tapu, and therefore food cannot be brought in. It is easy to imagine how a well-intentioned member of the hospital staff might bring tea into the room, thinking the family would prefer a cup of tea "in private". Unfortunately, this would create a violation of the tapu/noa separation and be seen as offensive.

As described by Dr Mason Durie:

*"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."*⁴⁶

Identifying issues and behaviours that will make Māori patients more comfortable in the healthcare setting will result in a mutually beneficial situation, where both patient and practitioner satisfaction increase and clinical outcomes improve.^{31,37,47-49}

Māori culture emphasises familial and community ties. Its world view acknowledges the wisdom of the past as well as its connections to the present, through historic places, ancestors, community ties, and the physical world.⁶ Keeping this in mind may assist non-Māori practitioners in understanding Māori patients' behaviours, such as bringing family members to medical visits and consulting with them before approving treatment, preferring face-to-face interactions with their practitioners, and expecting that first meetings (with any and all members of the medical team) will be handled formally and at an unhurried pace until a relationship is established.

Some areas where cultural differences may arise with a Māori patient include: establishing (and maintaining) a therapeutic relationship, interpreting (and sending) non-verbal signals, expressing agreement and disagreement, communicating medical information, allowing (and including) family members in medical settings, and praying. Although some or all of these areas may be important to an individual patient, you must remember that, like all other ethnic groups, Māori demonstrate great diversity within their community.⁶ However, in common with other New Zealanders, Māori patients are generally happy to educate a provider who demonstrates concern and respect for their wishes by asking about areas that may be unfamiliar or confusing.

“Taking a position of humble curiosity when working with Māori patients and their whānau enables us to get patients to teach us about their cultural realities, about their cultural understanding and explanatory models for what is happening. This is a very useful position to take and allows us to empathically engage in order to develop a plan with the whānau that is actually going to have a high degree of success.”⁴⁵

The most effective – and enjoyable – way for providers to understand the communities they serve is by establishing relationships with local Māori, including Māori health professionals in their area. Attending hui, sports activities, and community events at local marae will further strengthen the doctor-patient relationship, especially for community-based doctors.

Principles of culturally competent care for Māori

Māori views on health take a holistic approach and embrace four cornerstones of health:⁵⁰

- te taha wairua (the spiritual dimension)
- te taha hinengaro (the mental dimension)
- te taha tinana (the physical dimension)
- te taha whānau (the family dimension).

For Māori with traditional views, the wairua or spiritual well-being is not only key to one's identity but also provides the link with one's whānau, thus connecting the individual with the larger community that provides sustenance, support and safety.⁵¹ The mental (hinengaro) and physical (tinana) health are inextricably linked with the wairua and the other elements of a healthy life, including the physical environment. The relationship between Māori and the environment (te ao tūroa) is one of stewardship (tiakitanga).⁵¹ The environment is the continuous flow of life and constitutes an essential element in the identity and integrity of the people.⁵¹ As the Royal Commission on Social Policy wrote in 1988, "without the natural environment, the people cease to exist as Māori."⁵¹

Because of this holistic, integrated approach to health, beliefs about the nature of disease and treatment priorities for health may differ at times between Māori patients and non-Māori health providers; the Western approach emphasising personal dysfunction and socio-economic inequalities, and Māori concerns moving to wider cultural factors affecting the community as a whole.^{50,52} The key to health promotion, ie assisting the patient to achieve their

best possible state of health, is to understand their concerns and to work with them, within their cultural framework, to obtain the best outcome.

Māori community involvement

Whānau means family, sometimes in the direct and circumscribed sense of parents and children, but more often in the sense of a wider kinship group who share a common ancestor. The whānau is the basic unit around which Māori society is organised, and the welfare of one member is of concern to all.

The extent to which a particular Māori patient will belong to a more traditional whānau structure may depend on geography, life experience, proximity to other families and kin, and maintaining active lines of communication – often between countries. Keep in mind that Māori culture is dynamic; migration, mobility, changes in birth rates and reproductive patterns are influencing Māori family structure.

Nevertheless, many modern urban Māori families will embrace the elements of connectedness, duty, obligation and benefit within their daily lives. Dysfunctional Māori families, who are affected by drugs, alcohol, violence and/or sexual abuse, may have these problems compounded by the complex interconnections, obligations, and intricacies of wide family bonds. That is, the problems may be multiplied through generations and across family groups, and therefore interventions to address these issues need to take place at the level of that wider whānau to be effective, sustainable and acceptable.

As a result of this 'interconnectedness', it is common for Māori patients to bring family or whānau members with them to appointments, and they may need to consult with them before accepting any treatment recommendations. Some Māori may feel more comfortable if a member of the whānau speaks on their behalf. Sometimes this can lead to a slightly longer interview so that the whānau can consult before decisions are made, but you should realise that in addition to providing greater comfort to the patient, the presence of these other whānau members can lead to improved care. For example, they can provide additional background information during the medical history, help the patient to understand your instructions, and assist the patient in carrying out treatment.

Ethnicity data collection and use

Accurate and consistent collection of ethnicity data is essential to providing the best clinical care. Without this information, and similar socio-demographic data such as educational level, religious affiliation, lifestyle, marital status, and dietary habits, providers will be unable to provide individualised care – that is, care based on the background and cultural understanding that a patient brings to the encounter.

In addition to the ability to tailor care to the patient once ethnic information is known, such data collection can also benefit the health system in general, as psychiatrist Dr. Felicity Plunkett explains:

“Mental Health Services need to assess how well all population groups are served and with which disorders Māori present, compared to non-Māori. In order to answer these and other questions it is critical that clinical staff collect ethnicity and diagnostic data accurately. However the Public Health Consultancy of the Wellington School of Medicine and Health Sciences in developing a Population Needs Assessment for twelve of the provincial DHB’s noted considerable difficulties in needs assessment for Māori due to ethnicity data not being accurately and consistently collected.”⁵³

Make it a standard part of your practice to ask every patient what their ethnic background is; do not make assumptions based upon skin colour or appearance. By asking the question, you not only reveal your respect for the patient’s individual heritage, but you also have an opening to discuss their cultural preferences. Be sure to provide all patients with an explanation of why, how and when the information will be used, and reassure them that, like all medical information, the information is treated as confidential. It is also critical that you do not argue with or challenge the patient’s view of their ethnic affiliation.

In earlier times a Māori was defined as someone who was ‘half-caste or more’. That definition has been superseded by two approaches. One is based on being descended from a Māori, the other from identifying as a Māori. Be aware that some patients may identify themselves as being multi-ethnic, while others who are descended from a Māori may choose not to identify as Māori. However, if the questions

are asked in a consistent manner, with full explanations, and the patient is given enough time to answer, it is unlikely that anyone will find a question about ethnicity inappropriate or offensive. Quite the reverse, you may find that your patients welcome the opportunity to share with you how they see their cultural heritage and their health interacting. For example, if a patient were to say, “Oh, my family’s Italian (or Tongan or Samoan or Māori), and food is such a central part of family life, there’s no way I will ever not be overweight. There’s nothing I can do about it”, you could take the opportunity to offer nutritional advice that is still culturally sensitive or propose an exercise regimen that could counteract dietary indiscretions. See Cases One and Five below for Māori examples of how knowing about a patient’s culture can help you in improving their health.

The central place of effective communications

The greatest value of cultural competence is to enhance communication between you and your patient: to ensure that the consultation is of value for both of you; that the information needed is shared between you and the patient (and perhaps their whānau); and that the desired outcome (the best possible health for the patient) is achieved.

Be aware that many Māori have a natural desire to seek a consensus – to avoid disagreements about small matters. They may defer to the authority of those in the practice team who are, after all, experts in health care, but that does not necessarily mean they agree with what you are saying. The

values of harmony and respect may be more important than expressing disagreement. Unfortunately, this desire for consensus in no way means that, once they are out of your presence, they will proceed with the treatment plan, and so it is very important to ensure that “yes” means “We have agreed upon this plan and I will do my part as we have discussed”, and not “I totally disagree and have no intention of doing what you have outlined, but I will not insult you by saying so to your face.”

Along these same lines, it is best not to take the silence of Māori patients as agreement with what is happening. In fact, silence by Māori may indicate complete disagreement with what is being proposed. In some this is stoic acceptance of treatment they perceive to be inappropriate, while others may not want to challenge the authority of the provider. A better approach is to check that patients have understood by the use of open questions. For example, you could say, “I want to be sure that I have given you all the information you need. Please tell me what you understand will happen to you, from what I have said.”

In addition, remember that each of us, regardless of background, has a personal preference for receiving information. You may need to deliver healthcare information in a number of ways to be certain that the patient has a sufficient understanding of the topic. This is a time when whānau members may be helpful in assisting you to ensure that sufficient information has been received by the patient, and also in checking on understanding and disagreements. The role of the patient is to receive treatment, while the role

of the whānau is to support the patient and negotiate with authority (ie you).

That said, there are also several ways to ensure that, if necessary, you can speak to 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 or unwilling to discuss in front of family members. In that case, it is entirely appropriate to say to the whānau, “There are a few questions that I would like to ask the patient that deal with private topics. Would you mind stepping out of the room for a few moments?”. If you feel this type of approach would be inappropriate, you can also wait for a time when you are alone with the patient for another reason and raise the question(s) at that point. For example, most Māori will request privacy for a genital examination, and that can give you the chance to raise any topics they might be unable or embarrassed to discuss openly.

Guidance on Māori preferences

Always be guided by the individual patient and/or their whānau when it comes to customary Māori practices, such as pressing noses (hongī) or reciting a blessing (karakia) at times of anxiety (such as before a medical procedure). If you make assumptions based on broad stereotypes, you are likely to end up embarrassing yourself and your patient, and impairing the doctor-patient relationship, rather than strengthening it.

It is important to be aware of gender issues when working with Māori whānau. As Dr Hinemoa Elder writes:

“As a Māori woman psychiatrist in training there are times when it has not been appropriate for me alone to engage with whānau and it has been really important for me to have a kaumātua working alongside me in order to make the process adhere to issues of tikanga. There are times when this is not possible though. Acknowledging that you know the appropriate tikanga for a situation [even if you cannot adhere to it] goes a long way to helping the family feel more comfortable about what is going to happen in that particular meeting.”⁴⁵

The following examples are provided to familiarise you with typical issues that may be important to a Māori patient; they are not meant to suggest that every Māori will feel the same way about any or all of these. Always tailor your behaviour to suit the needs and preferences of the individual, whether Māori or Pākehā.

Māori pronunciation and communication

Few Māori clients have access to Māori health providers, and the doctor and patient’s different cultural backgrounds can sometimes hamper communications. This difficulty can be addressed by developing your understanding of Māori language and communication. Māori language (te reo Māori) is the basis of Māori culture and is considered a gift from ancestors.⁵¹ It expresses the values and beliefs of the people and serves as a focus for Māori identity.⁵¹ For this reason, language and pronunciation are very important.

Learning how to pronounce Māori names correctly is perhaps the single greatest way to show respect to your

Māori patients. In general, Māori place great emphasis on the spoken word, with words often viewed as links among the past, present and future. In particular, the proper pronunciation of names is a sign of respect, and mispronunciation of Māori names and words is jarring to Māori ears.

If you are not sure about how to pronounce a Māori name it is best to ask the Māori patient before attempting it, rather than trying to pronounce it and then asking if you got it right. Although some cultures might appreciate the fact that you made the attempt, mispronunciation, no matter how well-intentioned, will still be painful to many Māori ears. For this reason, it is better to admit to the patient your difficulties with Māori names and seek their assistance *first*, then, with their coaching, you can attempt their name. Doing it in this order shows you understand the importance of names in Māori culture and demonstrates respect for the individual and their heritage, as well as an interest in learning more, something the patient will appreciate.

Like all patients, Māori wish to learn the name and role of the people involved in their care. Make a point of introducing yourself and any members of your staff to your patient and their family, rather than assuming this is 'unnecessary' or a 'waste of time'. Māori culture relies heavily on interpersonal connections, and sharing names is obviously a necessary first step for such a connection to be formed.

The Māori phrase 'kanohi kitea' conveys the meaning of 'a face which is seen', and this relates to the Māori preference to speak to another in person. Written submissions are

not an effective method of consultation for many Māori, and face-to-face dialogue is much more likely to result in effective communication.⁵¹ If, despite this, you choose to use written messages to convey information such as test results or medication instructions, be aware that illiteracy rates are disproportionately higher among Māori; you should thus take particular care to ensure that your patients understand their condition and your treatment plan, rather than simply relying on printed instructions.

Māori traditionally value eloquence, and so you should not expect a 'Just the facts, please' presentation in response to your questions. In addition, many Māori, in an attempt to avoid discord, will be more 'polite' than 'honest' and often will tell you what they think you want to hear, not what really is the case.¹⁵ Pākehā in general are adept at voicing dissent. Māori, by contrast, may express consent very strongly while, as a form of courtesy, dissent is unspoken and will be taken home for further thought and reflection, to be voiced at the next meeting.¹⁵

Also be aware that Māori are less likely to challenge treatment plans or ask questions than many non-Māori are, but their silence does not necessarily imply understanding or agreement on their part. This, coupled with the shyness which is common to many patients before a medical person, makes it imperative 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); and what results (both positive and negative) you

expect.¹⁵ Do not wait to be prompted for this; make it a basic part of your discussions with the patient.

As you can see, you need to be active about soliciting feedback from Māori patients, rather than forcing them to raise any questions or concerns. You can do this in a number of different ways: through indirect questioning, via family or whānau members, or by using Māori health workers or interpreters when available. It is important to be sure that the answer you think you are getting is the one that the patient really means!

Lastly, be careful of using medical jargon with patients.⁵⁴ 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 – perhaps even more importantly – to ordinary words that take on specialised meaning in a medical context. Examples of these would be ‘complain’, ‘deny’, ‘report’, or ‘claim’. These words are particularly prone to be misunderstood by a patient who upon overhearing a nurse say to a doctor, “Mrs Hepi is here, complaining of a headache for the last two days” may think that the nurse is accusing Mrs Hepi of whingeing, not recognising that she is using the word “complain” in its medical sense. Similarly, a family may be offended if the doctor charts, “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.

Because Māori are often less likely than other patients to ask questions or challenge a doctor whom they perceive to be acting inappropriately, it is particularly important to present yourself as open to questions, and to solicit feedback from the patient and/or whānau regularly.

Family/whānau support

Community and whānau support are a key part of Māori health. As mentioned above, the individual is defined in terms of their relationship to the whānau, and the whānau in turn has a responsibility to take care of its individual members. For this reason, it is very important that the medical team recognise that a Māori patient may wish for whānau members to be involved in all aspects of their care and decision making. This may take the form of nominating a person to speak on their behalf and/or the behalf of the whānau, consulting on all decisions, bringing food for the patient, staying with the patient (including overnight), and attending surgical procedures. It is particularly important that visits by whānau members are permitted when a patient’s death is expected and/or imminent.⁵⁰ (See also “Death and Dying” below.)

Initial contacts and protocols

In days gone by, it was considered rude to ask someone’s name directly, because traditionally this implied that the person was not of enough importance to be known beforehand.¹⁵ Many still adhere to this convention. To overcome this, you might ask for guidance on their name’s pronunciation, enquire about their background (“Where are you from, then?”), or try to establish a connection

(“I see you come from Rotorua; do you know the Douglas family?”).¹⁵ This helps to avoid any apparent (and unintentional) discourtesy and shows that you recognise the Māori tradition of identifying oneself through one’s family and connections.

On initial meetings, some Māori will expect formal introductions to take place, not unlike the powhiri, where space and time between a community and a newly arrived stranger are used to establish links and to begin cautiously to understand each other.⁵⁵

Taking time at the first meeting so that the patient (and their whānau) can learn about the practice team will lead to effective relationships. Members of the practice team should introduce themselves when they first meet a Māori patient and explain the role they have within the practice. This includes the reception staff who, after establishing these connections, could then explain after-hours arrangements, the way to make an appointment, and how to make payment of medical fees.

Remember that the proper pronunciation of names is very important to your Māori patients, and they may expect formal introductions to all those involved with their care. They will be making an effort to learn your names, just as you and your staff are learning theirs. A minor investment of time on the initial meeting will pay off in a long-standing, close relationship with not only the patient but their entire whānau. After the first meeting, your Māori patient may still prefer face-to-face communication, to be supplemented by phone or mail contact.

Even after the initial visit establishes the relationship, expect to spend a few minutes at the start of every appointment catching up with your patient about their entire whānau. In this way, you are acknowledging those relationships, the importance they have to your patient’s life, and your understanding of connections in Māori culture. You will be re-establishing and building on your own ‘connection’, ie the doctor-patient relationship, so that when you then move to the clinical part of the consultation, you can be sure that cultural barriers will not interfere with your care of the patient and the patient’s acceptance of your clinical judgement.

Examining patients

While it is common courtesy in many cultures to ask permission before touching or examining a person, it is particularly important to do so with Māori. You will, of course, have introduced yourself to the patient and any whānau members present before this point, but you should, prior to beginning any physical examination, explain briefly what you will do, why you are doing it, and request permission to proceed. Be aware that, depending upon the examination, some whānau members may choose to remain with the patient. You should ask the patient and whānau what their preferences are, rather than automatically asking family members to leave the room while you make your examination.

You may notice that a Māori patient wears taonga (valuables/heirlooms). If this is the case, only remove them if their presence poses a safety hazard. Taping them in place is generally considered preferable to removal. If they do pose

a risk, to the patient or the medical team, be sure to ask permission from the patient and/or whānau before removing them, and (if possible) allow them to be the ones to remove the taonga and retain it for safekeeping.

Physical contact

In Māori culture, the head is the most sacred (tapu) part of the body. For this reason, you must be careful to ask consent before touching the head, and avoid touching it casually. As part of the tapu/noa separation, it is also important that anything that comes into contact with the body (or bodily substances) should be kept separate from food (or items associated with food, such as dishes or tea towels). Because food is considered noa, you should never pass food (such as a meal tray) over a person's head, which is tapu. Doing so could be considered to strip the person of all personal tapu. Different linens can be used to ensure that items that touch the head are not mixed with those that touch the rest of the body.⁵⁰ For example, most non-Māori patients will be comfortable moving a pillow from beneath their head to under their leg (or vice versa), but Māori may view this as a violation of tapu. For this reason, pillowcases should be different colours, so that those used for the head can be differentiated from those used for other parts of the body.⁵⁰ Similarly, different flannels should be used to wash the head and the rest of the body.

Towels used on the body should never be used for food, and freezers used for food (or medication) should not be used for any other purpose.⁵⁰

Body language

Body language can be different between Māori and non-Māori. For example, although Māori have a preference for face-to-face communications so that each party can 'look upon the face' of the other, this is not a request for direct eye contact. Also be aware that you do not need to prolong eye contact – Māori often say that 'we listen with our ears, not our eyes'.

This is because for many Māori, looking your conversation partner in the eye sends a signal of conflict or opposition. Furthermore, if there are more than two participants, sustained eye contact can exclude the ones not actually speaking.¹⁵ By contrast, the Māori will look at a neutral spot and thus be better able to focus on what the speaker is saying and how he is saying it, rather than being influenced by his appearance.¹⁵

Sustained eye contact can also be interpreted as a sign of disrespect, especially when this involves gazing at authority figures such as doctors and nurses in a medical practice or hospital. It may be better to avoid prolonged eye contact with Māori patients as that may make them uncomfortable, or feel like they are being scrutinised or criticised or challenged.

Keep in mind that 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 draw upon other signals from the patient (or their whānau) to decide which is the correct interpretation. If you are unsure about this or any other non-verbal signal, ask.

Sharing information and consent

Since many Māori consider their individual health problem as the problem of the whānau, they may feel threatened if their family/whānau members are excluded from medical interactions, consultations, decisions, or procedures. Be sure to give patients the opportunity to tell you whom they would like to have present and how much information they would like you to share with the others. As with all things, be guided by the individual patient's preferences, rather than by general notions about overall Māori (or non-Māori) culture.

With regard to informed consent, Māori are like all other patients in needing as much information as possible, often presented in several ways. In addition, however, they may wish the information to be presented to their whānau, and to have the opportunity to discuss the matter with the whānau prior to giving consent. Remember that silence may not indicate agreement, so when obtaining informed consent, be sure to ask about the patient's understanding and solicit concerns with open-ended questions. It is in no-one's best interest for a patient, Māori or otherwise, to go into a procedure with a partial or inaccurate understanding of what is likely to happen.

Traditional medicine/Rongoa

Some, especially older, Māori may consult a tohunga before, after, or instead of, seeing a doctor.¹⁵ The tohunga is often an older relative who looks after the well-being of the whānau and will be very knowledgeable in human nature and psychology, as well as having great expertise in tapu and noa laws.¹⁵

Those Māori who adhere to the belief that illness is the result of wrongdoing or breaking of tapu may display symptoms consistent with illnesses called 'mate Māori'.¹⁵ It is therefore a good idea to ask your patients for their feelings, views or ideas of causality about their illness. Not only will this give you the opportunity to educate them about their bodies (should that be appropriate), but if a patient believes that mate Māori is involved, you can also suggest that he visit a tohunga or minister.¹⁵ While the tohunga or minister addresses that aspect of their condition, you can provide the help afforded by Western medicine.

Some Māori may also choose to treat their illness with rongoa, or Māori medicine produced from native New Zealand plants and/or herbs. Refer to the Council's *Statement on complementary and alternative medicine*²⁶ for further direction. The key message is to know of any alternative medicine your patient may be using, and to ask where you are unsure.

As with any patient's beliefs, do not ridicule or belittle Māori traditions or concepts of health. Whether your patient believes that their illness is due to mate Māori, clogged arteries, misaligned chakras, or evil spirits, your role is not to challenge their beliefs but to work with them in order to help them be as healthy as possible. Of course, if their beliefs are dangerous or make successful treatment impossible, it is appropriate to share your concerns and seek a compromise, but doing so in a respectful way is

much more likely to succeed than being argumentative, condescending, or patronising. See Case One (page 30) for an example of how you can effectively employ both traditional and Western medicine on behalf of a patient.

Karakia and use of cultural experts

Wairua (the spirit) is intrinsically connected to health, and many Māori regard karakia (blessings or prayer) as an essential way of protecting and maintaining spiritual, physical and mental health.⁵⁰

Karakia should of course be interrupted if the patient's condition or the well-being of others is in jeopardy. If this occurs, or if karakia are not possible due to extreme circumstances, the situation should be explained to the patient and whānau as soon as possible. If you are not available for such a discussion (perhaps because you are providing emergency care to the patient), then have a staff member speak to the family on your behalf. It is better to offer explanations multiple times rather than not enough. Be aware that water may play a role in the karakia for the purpose of spiritual cleansing.

Designated Māori staff (kaiatawhai) whose role is to support the spiritual and/or cultural needs of Māori patients and their whānau are employed in many institutions. Including these knowledgeable people in your healthcare team is an excellent way to prevent cultural misunderstandings between yourself and your patient.

Dr Elder writes:

“Working with cultural support workers... is similar to working with any kind of specialist. In this instance, they provide knowledge, skills and wisdom which give the best opportunity for setting up a safe and appropriate context for people to express themselves so that we can hear what is going on from their perspective. I have found that often Māori patients and their whānau don't trust the services we represent. Recognising this and having cultural support at hand can go a long way to developing trust and therefore hope. Our clinical goal of formulating an empathic understanding of what is going on for a person and their whānau makes this building of trust and engagement a central platform where the work can occur. I have found time and time again that whānau won't necessarily tell you what is really going on unless you demonstrate an openness and respect for their beliefs and values.”⁴⁵

Special issues

1. Surgery

In general, Māori dislike body mutilation, and this can affect how people regard the removal of diseased body parts. For this reason, it is important that you give a very clear explanation regarding surgical procedures, including what will be done and why. In particular, when body parts or tissue will be removed and/or examined, be sure that Māori patients are consulted about the final disposal of that material.⁵⁰

In some cases, the whānau may need to discuss the options before making a decision, and time should be allowed for this to occur, unless (as in the case of an urgent amputation) this could place the patient at risk.⁵⁰ If the whānau request that the body parts, tissue or substance be returned to them, this should be done unless there is an overriding safety concern.⁵⁰ In this case, the concerns should be explained to the whānau and patient, so that it is clear the decision was not an arbitrary or unreasonable one. In every case, provide explanations on handling and disposal of the material(s).

2. Anaesthesia

In common with most patients, Māori are concerned that they will be accorded proper respect and dignity while anaesthetised in the operating theatre. At the same time, many Māori may also have spiritual concerns about the status of the wairua during anaesthesia and how the life source is being protected and preserved. They may wish for whānau members to be present or karakia to be said, in order to ensure that their spiritual as well as physical welfare is being properly looked after. Pre-operative discussions with the patient and whānau should ascertain what concerns they may have as well as how those concerns may best be addressed. As always, frank, open conversations ahead of time can, when sensitively handled, prevent many problems from developing.

3. Mental health

Mental illness remains a serious health issue for Māori, and the rate of psychotic illness among Māori has been said to indicate a “culture under siege”.⁵⁷ First admissions to psychiatric institutions are higher for Māori than Pākehā, with roughly 20 percent of all Māori admissions related to drugs and alcohol.⁵³ In addition, more Māori are committed to hospital involuntarily, under the Mental Health Assessment and Treatment Act, which increases the likelihood that the patients will consider the hospitalisation experience as punitive rather than therapeutic.⁵³

The increase in diagnosed mental illness among Māori holds for both genders. Māori women are at higher risk of alcohol and drug abuse and of being admitted to a psychiatric facility than non-Māori women, while Māori men are more likely to be treated in a forensic care setting, to be diagnosed with schizophrenia, and to spend less than half the time in hospital for this diagnosis than non-Māori.⁵³

The psychiatric readmission rate for Māori is twice that of European New Zealanders, and Māori are diagnosed with schizophrenia at higher rates than Pākehā.⁵³ Worryingly, this may not reflect the true rate of schizophrenia among Māori, as many of these patients recovered rapidly and did not follow the longer-term course of schizophrenia.⁵³ This suggests that lack of understanding about these Māori patients,

including ignorance of Māori culture, may cause non-Māori clinicians to misdiagnose major psychoses when the patient's condition is in fact entirely different. At present, due to patchy health service data-gathering and confounding factors such as barriers to presentation, it is not known whether the true prevalence of mental illness in Māori is in fact higher or lower than that of the rest of the population.⁵³

4. Pain

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.

5. Hospitals

Many Māori are reluctant to be admitted to hospital, in part because they consider them “places where people die”.¹⁵ Since the (non-Māori) hospitals do not consider death tapu, the hospital rooms and beds may not be properly cleansed (by Māori standards), creating worry or discomfort for Māori patients. In addition, Māori are accustomed to being surrounded by friends and relations, particularly when they are ill. Hospitals that place restrictions on hours and number of visitors can make the unpleasantness of a hospital stay even worse. If limitations on visitors are necessary, be sure to explain the rationale to the patient and their whānau, and work with them to find the best possible compromise.

Hospital food is a problem for many patients, Māori and non-Māori alike. If you work with the whānau to ensure that usual foods are brought to the patient during their stay, the hospital will be less foreign and uncomfortable. If you do this, however, remember that there are many important cultural practices that relate to the consumption of food.¹⁵ It would be counter-productive to have the whānau go to the trouble to bring food, only to have it rendered inedible by inadvertent actions on the part of hospital staff, such as its being brought into contact with something considered tapu.

6. Mate Māori

Dr Durie describes *mate Māori* as follows:

“Mate Māori ... refers essentially to a cause of ill health or uncharacteristic behaviour which stems from an infringement of tapu or the infliction of an indirect punishment by an outsider. The prevalence of mate Māori has never been recorded although there are published accounts of isolated cases of the condition and its management. It may take several forms, physical and mental, and various illnesses not necessarily atypical in presentation may be ascribed to it. ... Thus there is no single clinical presentation and clinicians need to be alert to the possibility that relatives may have considered the possibility of mate Māori.”

“Most families will be reluctant to discuss mate Māori in a hospital or clinic setting, fearing ridicule or pressure to choose between psychiatric and Māori approaches.”

In fact, one approach need not exclude the other; cooperation between traditional Māori healers and health professionals is now becoming acceptable to both groups. Mate Māori does not mean there cannot be a coexisting mental disorder. At best, the term is a comment on perceived causes of abnormality rather than on the symptoms or behaviour which might emerge. Yet it remains a serious concept within modern Māori society, and to many people, mate Māori sounds more convincing than explanations that hinge on a biochemical imbalance or a defect in cerebral neurotransmission.”⁴⁶

Death and dying

Death and dying are times of stress in any culture, and every culture has certain rituals surrounding these times. Some cultural ceremonies are more complex than others, and most, when unfamiliar, can seem odd or intimidating. For Māori, death and dying are deeply imbued with cultural significance, and it is not uncommon even for Māori who are otherwise relatively unobservant to follow very traditional practices when they or loved ones are near death. The communal nature of Māori society is particularly apparent at these times of stress, with whānau members from all over hurrying to visit and stay with the patient. A medical team's ignorance of Māori practices could unintentionally make a difficult time for the family infinitely harder, for example by interfering with the family's need to see and speak to the deceased.⁶

For this reason, it is particularly important for the family to have familiar faces on whom they can rely. This is a time when Māori families, like most others, may be very dependent upon their GP for help in understanding their medical environment. Even if the patient's care is mostly in the hands of specialists, do not forget that the GP is likely to have the strongest relationship with the family, and for that reason should continue to be involved in the patient's care and in the discussions with the whānau. Times like this will make or break your relationship with the whānau, and your continuing close involvement can do an enormous amount to alleviate 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 interface 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 painless as possible, under the circumstances.

The Māori view of dying and death is quite different from the non-Māori view, as is the Māori way of grieving for the dead. In Māori culture, the past is considered 'in front of' us because we know about it, understand it, and our current actions are based upon it, while the future cannot be seen and is thus considered 'behind' us.¹⁵ This is completely opposite to the Western view of 'past behind' and 'future

ahead'.¹⁵ To a Māori, then, the dead are the basis of one's very existence in the present and are an important part of current life.¹⁵

When old people are near to death, Māori may delay consultation until very late.¹⁵ This is not due to a lack of caring or to a misunderstanding of the condition's severity, but could be because the old person only wishes you to confirm his belief that death is imminent. He 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 whānau's wishes and expectations are. Keep in mind that whenever possible, many whānau will prefer to take a terminally ill patient home, rather than have him die in the hospital.

As might be expected, given the importance of the past and one's ancestors in Māori culture, Māori mourning and funeral rites (tangihanga) are important and complex. Whenever possible, it is best to ask the whānau spokesperson (or the patient) about their preferences. Māori staff or knowledgeable community members may also be able to help determine the family's preferences.

In nearly all Māori families, a death will be an occasion for family, whānau and wider relations to gather together to perform the appropriate farewell customs. The tangihanga will be held over several days. It may take place at the deceased person's home or a family member's home, but more commonly it is held on a marae.

Māori believe that when a person dies, his body (tūpāpaku)

is not vacated immediately by his spirit (wairua).¹⁵ The wairua is believed to wander at will, leaving and returning to the body for three to five days. After this, the wairua walks the path from Awanui (the southern point of Ninety-Mile Beach) to the northern point of New Zealand, then dives off and proceeds to the Underworld of Hine nui-te-po (the Goddess of Death) and then to Hawaiki or Tawhiti, the ancestral home of Māori.¹⁵

The tūpāpaku will likely be attended at all times, and visitors will talk to it, recalling his life, his good points and failings, and helping the wairua gain strength for its upcoming journey.¹⁵ This is the wairua's last days on earth, and the funeral rituals are to provide an appropriate farewell to the person and to instruct the wairua to depart.

For this reason, the whānau should be notified immediately if they are not present when a patient's death is imminent. The family will want to be present with their relative and remain with them after death occurs, so a private room should be provided. The whānau may wish to wash and dress the body themselves, so their preferences should be determined and, wherever possible, honoured.⁵⁰ Try to allow the family adequate time to grieve before moving the tūpāpaku, but remember that food and drink must not be taken into the room with it. Everyday linen cannot be used to wrap the tūpāpaku, and the whānau should be consulted as to how the tūpāpaku should be moved, as well as whether they wish to accompany it.⁵⁰ The body should be transported feet first, and public areas should be avoided wherever possible.⁵⁰

Following the removal of the tūpāpaku from the hospital room, karakia will be performed, following which the room can be physically cleaned.⁵⁰

Because of the belief that the wairua wanders, a patient's whānau may be very upset if their loved one's body is kept in hospital over a weekend, or any other extended period of time, rather than being released to them. It means that during the vital days of the wairua's wanderings, no one from the whānau will be present to grieve for or protect the spirit, and it also places an extra burden on family members who have come to pay their respects at the funeral ceremonies by increasing the length of their visit.¹⁵

During the tangihanga, the family will host all visitors to the marae. This can be a huge undertaking in terms of both the human and financial resources needed to complete these obligations, so be aware of this when dealing with the family of a seriously ill or dying patient. Some whānau members, for example, may be thinking about or planning for the tangihanga when they ask you about the patient's prognosis or when the body can be released. The more you can understand what is going through their minds, the more help you can be to them at this critical time.

In particular, anything that delays the tangihanga can create very strong feelings of resentment within the whānau, and it is therefore very important that you 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 tangihanga and burial, there will usually be a substantial meal, a hakari. An official period of mourning may be observed which could extend anywhere from three months to twelve months. A headstone unveiling, the hura kohatu, will often take place within three months to two years after the tangihanga. 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. Remember the Māori concept of kanohi kitea, 'the face which is seen'. This concept is particularly important during tangihanga, when extended family will travel long distances so that they may be present at the tangi. In the same way, your presence at the funeral will go far towards establishing you with the whānau, as it will show that you understand the importance of attending and letting *your* 'face be seen' as a member of the community and a friend of the deceased.

Autopsies

As with all groups, Māori expect a complete and accurate explanation any time that a post-mortem is required, whether it is a coronial or non-coronial procedure.

In addition, Māori may wish to be present during the procedure, and the tūpāpaku should be released to the family as quickly as possible afterwards. The removal or cutting of any hair from the tūpāpaku should be avoided whenever possible;⁵⁰ if it is necessary, an explanation should be made ahead of time to the whānau. Any tissue, body

parts or fluids taken during the autopsy should be handled sensitively, with close consultation to determine the family's preferences for return, retention or disposal.

Case studies

CASE ONE: “Smoking Can Be Bad for Your Health”

Recognition of complementary world views

A 62 year old Māori man who works in a bank visited his Pākehā GP because he didn't feel well. As the consultation progressed, the doctor felt that it was not going too well, so he shared these thoughts with the patient and asked if there was something else bothering him. The patient sighed and said yes. He said, “I know what's wrong, doc. I know why I'm crook. I took tobacco to the urupā and then had a smoke.” The GP told the Māori patient that he didn't know what the significance of that was and asked if he could explain. The patient revealed that the urupā is tapu, while cigarettes are noa, so he had committed a serious breach. The doctor asked the patient if he knew what he had to do about that. The Māori patient heaved another sigh and explained that he had to see a priest.

Without deriding the patient's belief system (“No, no. The tobacco has nothing to do with it – you've got heart failure caused by a decreased cardiac ejection fraction secondary to hypertension and atherosclerosis.”), the doctor acknowledged that while the patient sought assistance for the violation of tapu within the Māori culture, he could prescribe medicines to help with the breathlessness.

The patient's firmly held belief as to why he is unwell ('disease attribution') is rooted in his cultural world view: he's unwell because he's breached tapu by taking tobacco into urupā and then smoking it. It is generally non-productive

to argue disease attribution with a patient, as it is usually perceived as a sign of disrespect to their belief system.

By contrast, if you can show respect for their beliefs while simultaneously offering complementary assistance from the world of Western, orthodox medicine, your suggestions are much more likely to be adopted. In this case, the GP was comfortable with his patient's maintaining his disease attribution and following the correct protocol for dealing with that breach of tapu, but he simultaneously offered supportive treatment for the breathlessness associated with heart failure. The patient was comfortable with the idea of seeking help from both Māori and Western cultures, and accepted the GP's prescribed treatment.

CASE TWO: ‘She Never Showed Up!’

Practice bad manners

A Māori woman named Miriama Te Kani went to the after hours service after cutting her hand while preparing dinner. After signing in, she and her husband waited patiently to be seen. After several minutes, a nurse came out and called for “Mrs Tickanee”. Mrs Te Kani did not recognise this as the nurse’s attempt to pronounce her name and assumed she was calling a different patient. The nurse called a few times more, then summoned a different patient. This happened several more times over the next 90 minutes.

The nurse became frustrated at the thought of a patient leaving and expressed her frustration to her colleagues. “It was a bad cut too! I don’t know why she would leave. I get so angry when people don’t take proper care of themselves. You wonder why she bothered to come in the first place!”

Meanwhile, Mr and Mrs Te Kani were getting increasingly upset themselves. Mrs Te Kani’s hand hurt, and both she and her husband had seen many people who had arrived after her, and who looked much healthier, being called back to be seen by the doctor. She thought about going and asking why she hadn’t been seen, but finally decided it wasn’t worth it. The Te Kanis left and drove 60 minutes to the public hospital where her cousin worked. Mrs Te Kani was seen within 10 minutes.

Case studies continued...

CASE THREE: “We Are Family”

The whānau factor

A 47 year old Māori woman presented to her GP and was diagnosed with diabetes. The GP, through her conversation with the patient about ethnicity, realised that for this woman, like many Māori, the whānau formed the basic unit of her society, and thus it needed to be the basic unit for medical intervention. The GP made sure that rather than educating only the patient about the disease, she worked with the family as well. It is unlikely that the patient would change her diet unless her whānau was also brought into the consultation, so the doctor sat down with several members of the family and explained to everyone about diabetes, the pancreas, insulin, glucose levels, finger prick testing, pharmaceutical interventions, diet and exercise, complications and preventing complications. Since the patient was one of the family's main cooks, she would not change her diet or have a refrigerator full of healthy salads and diet food while cooking all night for the rest of her family. It was also important for other family members, such as her daughters-in-law who also did some cooking, to understand how her diet needed to change.

The GP also recognised that, with the incidence of diabetes and obesity disproportionately high in the Māori population, it was likely that other members of the whānau would develop diabetes in the future. She knew that by educating

the entire community and encouraging healthy changes in everyone's diet and exercise habits, she had the opportunity to prevent or delay those cases. Accordingly, when talking about the importance of exercise in keeping diabetics healthy, she led a discussion on whānau-based exercises in which the entire community could participate regularly. She also referred the patient (and her whānau) to a Māori dietician who could use her knowledge of foods commonly used in Māori cooking to help the patient substitute healthier, but still culturally acceptable foods, for example, using karengo (seaweed) in salads. The dietician also explained portion sizes in appropriate ways and discussed how the patient and other whānau cooks might handle hui and other events where food will be provided.

Although this educational session took a bit longer than the average consultation, the GP felt that it was an excellent investment of time and energy. Over the next 12 months, she was proven correct, as she found that not only was her patient's diabetes well controlled and her borderline hypertension dramatically improved, but several other members of the whānau also lost weight and adopted exercise patterns because of their improved understanding of diabetes as well as the different diet options now available to them. Basing treatment decisions on the goal of having the patient remain healthy and active in her role as mother and grandmother to future generations allowed the GP, the patient, and the whānau to achieve the best possible results.

CASE FOUR: “Everyone Benefits”

Practice benefit of collecting ethnicity data

A GP was taken aside by his office manager who said, “You know, now that the practice has started asking all our patients to identify their ethnic background, we’ve discovered that our proportion of Māori patients is much higher than we thought. But they use our services at much lower rates than expected – we should discuss this at our next practice meeting.”

Case studies continued...

CASE FIVE: “Who Knew?”

Patient benefit of collecting ethnicity data

A GP in Invercargill has just finished examining his new patient, a 26 year old woman in her first pregnancy. The patient has been gaining more weight than expected and is not feeling very well, but her GP has reassured her that it is normal to feel “different” during pregnancy and that she shouldn’t worry, as she is otherwise healthy and there is no reason to expect any complications. As the GP is completing his documentation outside the exam room, his nurse asks if he has any special instructions for the patient. “No, just the usual, Fiona,” he replies cheerfully. “She should have no problems, a healthy young woman like that.”

Fiona looks a bit surprised. “Really? I thought Māori women were at higher risk for gestational diabetes, even with their first babies.”

The GP blinks. “But that patient isn’t Māori.... Is she?”

The nurse nods. “We were in school together here, and I remember her talking about her background. You know that 13 percent of the Invercargill population reported at least some Māori heritage at census time.”

The GP goes back into the room and reseats himself. “I’m very sorry, but I forgot to ask a few of my basic housekeeping questions. One of them has to do with ethnicity. I ask this question of everyone, and like all of

your personal information, we treat it as confidential. I use this information to make sure that I am tailoring your care to your individual needs. Would you be comfortable telling me what your ethnic or cultural background is?”

The patient smiles. “Of course. I am Welsh, Māori and German. I’m glad you asked, because I would like to make sure that my family can be with me during the delivery, and I know my grandmother will want to have karakia.”

“I’m certain we will be able to accommodate that. I’ll make sure that the hospital knows about your preferences, and that our kaiaatawhai is notified. Now, your Māori background does put you at a higher risk of gestational diabetes, so I’d like to do one more laboratory test, just as a screening precaution. Is that all right?”

“Oh, yes. Whatever you think best.”

“Fine. My nurse will get you the paperwork, but essentially this is just to make sure that your body – and the baby’s – is handling sugar properly and growing at the proper rate. I’ll let you know once we have the test results, and we can discuss the findings. Would you like me to call you with the results, or would you rather come in?”

“Oh, a phone call will be fine, but at my next check up, my mother and some of my aunties will probably want to come.”

“That’s lovely. I look forward to meeting them.” The GP leaves the room, amends his chart, and writes himself a note to order flowers for Fiona.

CASE SIX: “If Only He Had Asked Earlier”

Build a relationship with the community

A non-Māori GP, who lived and worked in a coastal area renowned for excellent rock fishing, had built a solid relationship with the local Māori over many years of practice as the sole GP. Many of his patients were Māori from the local iwi, and he would attend their community cultural and sporting events as often as he could. The tangata whenua held him as a valued person in their community.

On a rare Sunday free of commitments, the GP decided to head down to the beach with his son to go rock fishing. They got to the beach with all their equipment to find that the track to the fishing spot had been barricaded. Scrawled signs posted nearby stated: ‘Fishing Prohibited’ and ‘RĀHUI’. The GP, unwilling to cause a fuss, decided to head home with his son. On his walk to the car he noticed a group of Māori going through the barricade and down to the fishing spot. The GP was very angry that he had been turned away, with his son, while the local Māori had been let through, especially as he felt he had connected with the tangata whenua.

Over the next week the GP continued to feel upset, and this showed at his practice. He did not sit and chat with his Māori patients as he would have and did not attend any local community events.

The next Sunday he decided to visit one of the local kaumātua to find out why he had been restricted from the local fishing spot but others (Māori) had been let through. He explained his feelings of anger, hurt and disappointment to the kaumātua.

She smiled and shook her head. She explained: “our people value you and your family. You welcome us into your clinic, you attend our functions and you are always willing to attempt to understand our ways. On that day you would have seen a sign that said RĀHUI. This means prohibition. You may recall a week earlier one of our young nephews drowned along that coast; he has not yet been recovered. A dead body, or tūpāpaku, is considered tapu. We cannot collect food for eating where a tūpāpaku may lie hidden beneath the rocks. Until he is found, our people will continue down to those rocks for karakia (prayers) and the rāhui will remain. This is why you should not fish there.” The GP immediately understood.

Case studies continued...

CASE SEVEN: “Such a Simple Solution”

Importance of face-to-face interaction

Mr Huata was a 47 year old Māori man who had been injured in a crash during his work as a heavy vehicle driver. The health professionals involved in his care were finding it hard to maintain a pleasant demeanour with him, because he often seemed surly and uncooperative when they spoke with him on the telephone. They raised the issue during a team meeting, and a Māori staff member at ACC suggested a face-to-face meeting with the patient and all those involved in his case.

A meeting was arranged with Mr Huata, his employer, ACC staff, the Pae Arahi from the ACC branch, and Mr Huata’s whānau. After a formal welcome and refreshments provided by the whānau, everyone present introduced themselves and Mr Huata voiced his concern that, not only had he never

actually met most of the people present, but he had also been receiving conflicting advice from his different providers. He expressed his frustration with what he saw as a very confusing treatment plan with no clear return to work date. He also explained that he was worried that his rehabilitation plan would interfere with his responsibilities at the marae.

With everyone present in the same place at the same time, it was easy to develop a plan for Mr Huata’s further care that not only provided him with a graduated return to work but also ensured that he would be able to maintain his marae duties. Regular face-to-face meetings between Mr Huata and various groups were scheduled, and within weeks, Mr Huata had become one of the healthcare team’s favourite patients, with his strong motivation to get the most from his rehab as well as his interesting stories of life as a truck driver. He quickly made significant progress towards returning to his normal routine and soon rejoined the paid workforce.

CASE EIGHT: “Health of the Body, Health of the Mind”

Culturally competent health care for better outcomes

The following vignettes are excerpted from Dr Plunkett’s description of working with Māori patients in a culturally competent fashion,⁵³ as found on the Te Iho website (www.teiho.org):

“We had admitted a young Māori woman (whom I will call Karena) to the acute ward, who was extremely unwell with a very severe manic state. At that point we had no ICU so she was treated in the Quiet Lounge and her whānau all stayed with her to help with her care. It was her first episode of psychiatric illness so it was important to get it as right as we could, to prevent her being traumatised and so that she and her whānau would have a better relationship with mental health services in the future (as a manic state generally means coping with ongoing episodes of a bipolar disorder).

“I’ve never looked after anyone so acutely unwell, and Karena initially absorbed huge doses of anti-manic medications with initially hardly any benefit or even sedative effect. Her whānau organised themselves into a system of shifts across the wider whānau, so that three people were with her at any time, and if it had not been for their devoted care I’m sure she would have spent a lot of time in seclusion (a simple, quiet, locked room with a bed on the floor). As it was, they managed her somehow, even though she was very chaotic with changeable moods and erratic impulsive behaviour, for the few days until lithium, a mood stabilising

medication, began to work and settled her moods and her agitated state. Throughout this Karena’s whānau lived at the ward, and our Māori cultural worker spent a lot of time supporting them and helping us to work with them so as to manage this difficult situation. In the end Karena recovered fully and her whānau were pleased that they had been able to care for her within the ward, as they had not been able to cope at home prior to admission.

“A young Māori man whom I will call Matiu had been admitted and was in the ICU wing. Matiu had made a suicide attempt and appeared paranoid and angry on admission, but thereafter became mute and refused to speak to anyone. It was generally assumed that he must be psychotic, probably with persecutory ideas, and that this was making him reluctant to speak...I sensed that he was angry and that he was deliberately mute for some reason.

Our Māori cultural worker arranged a whānau meeting to help us to assess Matiu, and as we needed background information and to make some decisions about what if any treatment he needed. Several of his whānau came from all over Auckland, including his mother, two brothers and a sister, and an aunt. The whānau meeting was opened with a speech from Matiu’s older brother, then a karakia.

After some general discussion in which he did not participate, his mother talked of her concern for him, and of how he had frightened them by the suicide attempt. Several of the whānau tried to get Matiu to say what was happening for him, but he remained mute. Our cultural worker asked the whānau whether there were issues affecting them as a

Case studies continued...

family that might have an impact on Matiu, and they talked of his younger sister who had been abused by a babysitter and who was having counselling for this after finally telling her mother what had happened when she was young. Matiu made no comment on this, and in the end I confronted him gently, saying that I did not believe that he was so unwell that he could not talk, and that I felt he was angry. He finally began to talk to his whānau, angrily telling his mother that his sister was not the only one molested, and that he had been as well, but had been unable to tell them. He talked of his anger that the family circumstances at that time had allowed this man to have access to the children, and that his mother should have prevented it somehow.

Matiu and his mother wept, and she comforted him, and they were able to talk about it with less anger and more understanding. There was no sign of any psychosis at all, and it was clear that his rage and pain about the abuse was the key reason for his admission and prior behaviour. Just

in talking to his whānau and especially his mother about the abuse, his healing had begun, and it was within the safe structure of a whānau meeting with proper rituals of opening and closure that he finally felt able to manage this. In this context, his whānau had also felt safe enough to raise the issue of abuse affecting his sister, and without them broaching the topic I doubt that he would have been able to talk of his own abuse.

This whānau meeting was intense and charged with feelings, and even after we had talked of helping Matiu arrange counselling and about setting in place crisis team support after discharge, it was essential to have the meeting closed formally, with another short speech and a prayer, so that everyone could wind down and manage ordinary tasks again. After the meeting we all shared a pot of tea and some biscuits, and that was also important to the whole process, before Matiu was discharged to the care of his whānau.”

Summary

Working towards a healthy Māori future is part of New Zealand's commitment to the Treaty of Waitangi. Health promotion has been defined as the process of enabling people to increase control over and improve their health, not by changing their beliefs or values, but by assisting people to assert control over their health and encouraging them to determine their own good health and well-being.⁵¹ For Māori, promotion of good health involves assisting whānau to make the choices necessary to regain and maintain their health.⁵¹ However, the involvement of Māori as active participants in the drive to improve their own health can only occur if the necessary resources – including the practitioners themselves – are accessible, available, acceptable, and culturally appropriate to Māori.⁵¹

Just like people of other cultures, Māori place great emphasis on establishing a trusting relationship with their healthcare providers. Client satisfaction and acceptability of treatment reflect the ability of providers to show they understand their patients and are understood by their patients. Improving providers' knowledge of Māori traditions will increase their cultural competence, thus helping them to communicate more effectively with their Māori patients. This, in turn, will reduce patients' delays in seeking care, improve the collection of clinical information, increase the understanding of Māori clients, and enhance communications between Māori clients and providers. Together these can lead to improved patient/family/whānau satisfaction and greater compliance with individual care plans.

“Health [is] not something that can be prescribed by the doctor, but something which should arise from within communities; and the leaders of health [are] not doctors or nurses, but community leaders who can use their influence and wisdom to alter lifestyles and living conditions.”

– Dr Durie⁵⁸

Glossary of Māori words

Hakari: feast following a funeral

Hapū: sub-tribe

Hawaiki: ancestral home of the Māori

Hineahuone: first human being, a female

Hinenuitepo: Māori goddess of death

Hinengaro: mental or psychological

Hongi: the practice of touching noses and mingling breath

Hui: community meeting

Hura kohatu: headstone unveiling

Iwi: tribe

Kaiatawhai: Māori healthcare staff whose role is to support the spiritual and/or cultural needs of Māori patients and their whānau

Kanohi kitea: a face which is seen

Karakia: prayer, blessing, incantation

Kaumātua: elder, grandparent

Kawanatanga: improvised word translated as setting up a government

Mana: power, respect, status

Manuhiri: visitors

Marae: community house, meeting place

Marae komiti: elders or leaders that guide the community

Mate Māori: illness that results from wrongdoing or breaking of tapu law

Noa: ordinary, safe

Pākehā: non-Māori, white

Papatuanuku: Earth Mother

Pataka: Store house for food

Powhiri: ceremony of welcome

Rāhui: prohibition

Rangatiratanga: chieftainship, authority

Rongoa: Māori medicine produced from native plants and/or herbs

Tangata whenua: people of the land

Tangihanga: Māori funeral rites

Taonga: treasures, precious possessions, can refer to both tangibles and intangibles

Tapu: sacred, forbidden, special

Tawhiti: ancestral home of the Māori

Te reo: the language, Māori language

Te taha: dimension, aspect

Te ao tūroa: environment, the land

Tiakitanga: stewardship

Tikanga: a set of rules for living, which both support Māori social systems and reflect Māori knowledge and traditions

Tinana: physical, bodily

Tino rangatiratanga: chieftainship, authority

Tohunga: traditional Māori healer

Tūpāpaku: cadaver, body

Tūpuna: ancestors

Urupā: cemetery

Wairua: spirit, soul

Whakapapa: genealogical connections over many generations

Whānau: family, community

Whanaungatanga: the importance of interpersonal connections

Whare: building, house

Whenua: land, placenta

References

1. Tapsell R. *Māori health in 2004*. In: Cole's Medical Practice in New Zealand 2005. St George, I.
2. Owens J. *New Zealand before annexation*. In: *The Oxford History of New Zealand*. Wellington: Oxford University Press, 1981.
3. Firth R. *Economics of the New Zealand Māori*. 2nd ed. Wellington: Government Printer 1959.
4. Orange C. *The Treaty of Waitangi*. City: Bridget Williams Books, 1987.
5. Pool I. *Te iwi Māori: A New Zealand population past, present, and projected*. Auckland: Auckland University Press, 1991.
6. ACC (Te Kaporeihana Awhina Hunga Whara). *Summary guidelines on Māori cultural competencies for providers*. Wellington: ACC, 2004.
7. Ajwani S, Blakely T, Robson B, Tobias M, Bonne M. *Decades of Disparity: Ethnic mortality trends in New Zealand 1980-1999*. Wellington, Ministry of Health and University of Otago. 2003.
8. Blakely T, Fawcett J, Atkinson, J, Tobias M, Cheung J. *Decades of Disparity II: Socioeconomic Mortality Trends in New Zealand 1981-1999*, Public Health Intelligence Occasional Bulletin #25. Wellington, Ministry of Health. 2005.
9. Ministry of Health. *Reducing inequalities in health*. Wellington: Ministry of Health, 2002.
10. Carr J, Robson BH, Reid P, Purdie GL, Workman P. *Heart failure: ethnic disparities in morbidity and mortality in New Zealand*. NZMJ 2002 Jan 25;115(1146):15-7.
11. Ellison-Loschmann L, King R, Pearce N. *Time trends and seasonal patterns of asthma deaths and hospitalisations among Māori and non-Māori*. NZMJ 2002 Jan 25;115(1146):6-9.
12. Sporle A, Pearce ,N, Davis P. *Social class mortality differences in Māori and non-Māori men aged 15-64 during the last two decades*. NZMJ 2002 Mar 25;115(1150):127-31.
13. Skegg DCG, McCredie MRE. *Comparison of cancer mortality and incidence in New Zealand and Australia*. NZMJ 2002 May 10;115(1153):205-8.
14. Ministry of Health. *Our health, our future. Hauora pakari, koiora roa. The health of New Zealanders*. Wellington: Ministry of Health, 1999.
15. Tipene-Leach David. *'Māoris: our feelings about the medical profession' in Primary health care and the community*. 1981. Note - this article is also available at: http://www.bopdhb.govt.nz/insideout/Forms/Culture_PreRead.pdf
16. Jansen P, Sorenson D, Jansen P, Sorenson D. *Culturally competent health care*. NZFP 2002 Oct;29(5):306-11 .
17. Durie M. *Māori attitudes to sickness, doctors, and hospitals*. NZMJ 1977;86:483-5.

18. Laveist TA, Nuru-Jeter A. [Is doctor-patient race concordance associated with greater satisfaction with care?](#) *J Health Soc Behav* 2002;43:296–306.
19. Westbrooke I, Baxter J, Hogan J. [Are Māori underserved for cardiac interventions?](#) *NZMJ* 2001 Nov 9;114(1143):484–7.
20. ProCare IPA. [Prescription Presentation Rates in South Auckland](#). Healthcare Management Associates and the Northern Regional Health Authority, 1996.
21. Marwick JC, Scott KM, Crampton PR. [Utilisation of general practitioner services in New Zealand and its relationship with income, ethnicity, and government subsidy](#). 2000. Presented at RNZCGP Annual Conference.
22. McNaughton HK, Weatherall M, McPherson KM, Taylor WJ, Harwood, M. [The comparability of resource utilisation for Europeans and non-Europeans following stroke in New Zealand](#). *NZMJ* 2002 Mar 8;115(1149):101–3.
23. Accident Compensation Corporation. [Report to Te Roopu Manawa Mai](#). Wellington, ACC, 2004.
24. Crengle S, Lay-Yee R, Davis P, Pearson JA. [Comparison of Māori and non-Māori patient visits to doctors](#). *NatMedCa Report* 6. 2006.
25. Gribben B. [Ethnicity and resource use in general practice in West Auckland](#). *Experience in Practice* 1999;1. Online article available at: <http://hcro.enigma.co.nz/eip/index.cfm?fuseaction=articledisplay&FeatureID=3> cited as: 31 March 1999 Vol 1, No 1: Ethnicity and Resource Use in General Practice in West Auckland
26. Ring I, Brown N. [The health status of indigenous peoples and others](#). *BMJ* 2003;327:404–5.
27. McPherson K, Harwood M, McNaughton HK. [Ethnicity, equity, and quality: lessons from New Zealand](#). *BMJ* 2003;327:443–4.
28. Smedley BD, Stith AY, Nelson AR. [Unequal Treatment: Confronting racial and ethnic disparities in health care](#). Washington DC: Institute of Medicine, 2003.
29. Arroll B, Goodyear-Smith F, Lloyd T. [Depression in patients in an Auckland general practice](#). *NZMJ* 2002 Apr 26;115(1152):176–9
30. Johnstone K, Read J. [Psychiatrists' recommendations for improving bicultural training and Māori mental health services: a New Zealand survey](#). *Australian and New Zealand Journal of Psychiatry* 2000;34:135–45.
31. McCreanor T, Nairn R. [Tauīwi general practitioners talk about Māori health: interpretative repertoires](#). *NZMJ* 2002 Dec 13;115(1167):U272.

References continued...

- ³² Ministry of Health. [Māori providers: Primary health care delivered by doctors and nurses: The National Primary Medical Care Survey \(NatMedCa\): 2001/02 Report 3](#). Wellington: Ministry of Health, 2004: xii.
- ³³ Tukuitonga CF, Bindman AB. [Ethnic and gender differences in the use of coronary artery revascularisation procedures in New Zealand](#). NZMJ 2002 Apr 26;115(1152):179-82.
- ³⁴ Sadler L, McCowan L, Stone P. [Associations between ethnicity and obstetric intervention in New Zealand](#). NZMJ 2002 Feb 8;115(1147):36-9.
- ³⁵ Baxter J. [Barriers to health care for Māori with known diabetes](#). NZ National Working Group on Diabetes and Te Roopu Rangahau Hauora a Ngai Tahu. City: publishing org, 2002.
- ³⁶ Crengle S. [The development of Māori primary care services](#). Pac Health Dialog 2000;7:48–53.
- ³⁷ Krupat E, Bell RA, Kravitz RL, Thom DH, Azari R. [When physicians and patients think alike: patient-centered beliefs and their impact on satisfaction and trust](#). J Fam Pract. 2001 Dec;50(12):1057-62.
- ³⁸ Bloomfield A, Logan R. [Quality improvement perspective and healthcare funding decisions](#). BMJ 2003;327:439–43.
- ³⁹ St George I. [Assessing performance 1: There but for the grace of God go I](#). NZFP Feb;31(1)45-7.
- ⁴⁰ St George I. [Assessing Performance 2: How should the underperforming doctor be identified?](#) NZFP Apr;31(2):112-4.
- ⁴¹ St George I. [Assessing performance 3: How well can peers and patients rate a doctor's performance?](#) NZFP Jun;31(3):189-92.
- ⁴² St George I. [Assessing performance 4: Reviewing communication skills](#). NZFP Aug;31(4):264-6.
- ⁴³ St George I. [Assessing performance 5: Assessing knowledge](#). NZFP Oct;31(5):337-8.
- ⁴⁴ St George I. [Assessing performance 6: Reviewing proceduralists](#). NZFP Dec;31(6):413-5.
- ⁴⁵ Elder H. [Te Iho Website – A Psychiatric Registrar's Viewpoint: Hinemoa Elder](#) (www.teiho.org).
- ⁴⁶ Durie M. [Mauri ora: The dynamics of Māori health](#). Auckland: Oxford University Press, 2001.
- ⁴⁷ Jansen P. [Managing your practice: Course aims to improve GPs' skills with Maori](#). NZFP Apr 1998;25(2):43.
- ⁴⁸ Cram F, Smith L, Johnstone W. [Mapping themes of Māori talk about health](#). NZMJ 2003 Mar 14;116(1170):1p following U353.
- ⁴⁹ Isaacs M, Benjamin M. [Towards a culturally competent system of care, Volume 2, Programs which utilize culturally competent principles](#). Washington DC: Georgetown University Child Development Center, 1991.

- ⁵⁰. He Kamaka Oranga Māori Health Auckland District Health Board. [Tikanga recommended best practice policy](#). Auckland: He Kamaka Oranga Māori Health Auckland District Health Board, 2003.
- ⁵¹. Ministry of Health. [He Tatai i te Ara: Guidelines for Developing Māori Health Education Resources](#). Ministry of Health, 1997.
- ⁵². Durie MH, [A Māori perspective of health](#). Soc Sci Med 1985;20:483–6.
- ⁵³. Plunkett F. [Te Iho Website – Disparities In Māori mental health](#) (www.teiho.org). 2003.
- ⁵⁴. Lockyear P. [Physician-patient communication: Enhancing skills to improve patient satisfaction](#). Medscape CME 2004.
- ⁵⁵. Durie MH. [Address to the meeting to launch Te Iho](#) (Auckland Regional Psychiatric Training website). City: organisation, 2003.
- ⁵⁶. Medical Council of New Zealand [Statement on complementary and alternative medicine 2005](#). Wellington: Medical Council of New Zealand, 2005.
- ⁵⁷. Bridgeman G, Dyall L. [Report on Māori Mental Health](#). Wellington, Ministry of Health, 1998.
- ⁵⁸. Durie M. [Nga kahui pou: Launching Māori futures](#). Wellington: Huia Publishers, 2003.

ISBN 0-9 582671-5-4



9 780958 267151 >

Updated October 2006