

Cultural Sensitivity and the GP

A Maori GP's Perspective

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Whether Maori have significantly benefitted from the developing cultural sensitivity of New Zealand health professionals is debatable

The mid-1970s was the time when medicine was just beginning to explore the dynamics of cross-cultural communication and its importance in the doctor-patient relationship. The issues centred on how Maori patients could be spiritually or psychologically different from non-Maori, and how this might affect the course of the illness, the necessary conduct of the consultation and compliance with the treatment prescribed.

In other words – 'good doctors' removing barriers between themselves and their Maori patients.

It became known as cultural sensitivity, and relied on motivating a professional responsibility and desire to do the best job possible, increasing the doctor's awareness of the (Maori) patient's situation, and thereby changing subsequent behaviour of the health professional.

Whether Maori have significantly benefitted from the developing cultural sensitivity of New Zealand health professionals is debatable. The outcome has perhaps been to make some health services a little less intimidating for some Maori patients, but there is no compulsion to practice sensitively, or any guaran-



tee that such sensitivity precludes a bad outcome for the Maori patient. Cultural sensitivity therefore remains a useful tool for those health professionals who find it so. For those who do not practice sensitively, market forces should lead the client to exercise their choice to change doctors.

Maori Community Health

The last 15 years have seen many changes in the organisation of health service provision and in the way that we practice family medicine. Equally so, the expectations of the doctor-patient relationship has changed for individual Maori and increasing confidence has led many to become more assertive and participative in their own health. The greatest change, however, has been in the influence that many in the Maori community are exerting over the shape of the health services that they receive. As medical and health

services have become more patient-centred, user friendly, publically accountable and efficiency driven, the Maori community are demanding health services that are appropriate, accessible and affordable.

Maori community-driven health initiatives have grown from small projects in single issue areas of primary care like the promotion of immunisation, into large multidimensional health and medical care schemes for tribal and urban groups.

This process began in earnest (i.e. Vote Health resources were allocated) after the 1984 Hui Whakaoranga at Hoani Waititi Marae in West Auckland. The Department of Health put Maori health up as a priority area and we saw the employment of Maori in health workforce as community health workers.

This was the beginning of a decade in which Maori became less willing to have health services 'done to them', and have demanded the (Treaty) rights of participation and indeed, partnership in developing the shape of their health services. The Puao-te-Atatu (The New Dawn: the Report to the Minister of Social Welfare of the Maori Advisory Committee, 1988) and the Tirohanga Rangapu (Partnership Perspectives: Maori Affairs Dept, 1989) Reports established the practice of consulting the Maori community when devising policy, allocating resources and developing services.

The advent of the health reforms and the promise of contestable funding has seen some major developments in autonomous and joint-

venture Maori health programmes, but, as yet, these initiatives have been developmental. When RHAs seriously entertain Maori health initiatives, and the funds become fully contestable, the Maori community will certainly take more control of primary care services.

In the 1990s many vital indices of Maori health now approach, if not equal, those of Pakeha. Some major indices, like falling infant mortality, approach that of non-Maori and other, e.g. life expectancy at birth, have increased tremendously, but many examples of very poor health outcomes abound. The comparably low Maori perinatal mortality is upset by a Maori cot death rate 3 to 5 times higher than the national one. Improvements in immunisation and well-child health care should be compared to the rising phenomena of welfare-dependent, single-parent, Maori family units.

Developments in child and adolescent health need to be compared to school failure, teenage crime and suicide among young Maori men.

As for the adults, we are last hired, first fired, end up in jail more often, have more welfare benefits, are admitted to psychiatric hospitals more often, have more addictions, and fill the ranks of this societies undesirable elements.

Part of good personal health is a faith in a secure and promising future for oneself and one's family. Maori people have had 2 such periods of time since colonisation. They were the international exporting years of the 1830s to 1860s when tribal groups owned fleets of trading ships that supplied Auckland and Sydney for years; and the period after World War II of urban migration, work and participation in the cash economy through to the full employment of the 1960s to 1970s. But the restructuring of New Zealand's economy in the 1980s has devastated the economic base of the Maori community, and the future for a largely unskilled young population does not look rosy. Our health prob-

lems are becoming increasingly dependent on our ability to participate in economic activity.

General Practice

But these particular variables are not really within our power to affect and are beyond the brief of most general practices to address. In the 1990s we need to be aware of the issue of cultural sensitivity, and the development of health initiatives in the Maori community. Although some in our profession may be well suited to work in the politically and socially motivated areas of developing appropriate delivery systems for Maori, the most of us will continue to work in our general practices, simply doing our best to do a good job for our Maori patients.

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The rest of this article covers some important aspects of Maori people's feelings toward doctors and other health professionals and a few tips that might make the doctor-patient relationship run a little more smoothly. However, remember that these are generalisations which are not applicable to every Maori who walks in through your surgery door. Maori, like everybody else, are spread across the spectrum of experience and knowledge when it comes to expertise in Maori things. Some people, especially the older and rural people, may well adhere to the things that follow in this article. At the other end, some young urban dwellers may not follow any of the particular attributes that we talk about.

Doctor-Patient Communication

Maori have become less and less wary of doctors over the years and now, rather than staying away from the doctor when they are in trouble, there is some evidence to say that we have an overall higher consultation rate than our non-Maori counterpart, but reports that the higher consultation does still not match the amount of need. The points that follow I find peculiar to Maori patients.

- It is considered rude to ask someone's name directly. In the old days this implied that the person was not of enough importance to be known. Today it is still the custom. In my practice I try to never ever ask anybody's name and the practice is organised in such a way that I never have to.

- Maori people will often give you the answers that they think you want to hear, saying yes when they mean no and vice versa. I often need to ask the same questions in 3 or 4 different ways at different times in order to establish what is really meant. Pakeha tend to voice dissent, and no answer at all implies a degree of agreement. Maori on the other hand will always consent very strongly, and dissent is taken home unvoiced for further thought and reflection. This behaviour slips over into the doctor-patient relationship.

- Further to that, Maori will often come to see you but give you only half the story, leaving out what they consider irrelevant, inappropriate or 'unsuitable for the doctor's ears'. We should never assume that we have the whole story.

- Maori will often show up at the clinic with the whole family, all having something wrong, from the baby who has been ill for one day, to the two aunts complaining of their 3-year-old problems. 'Wait until we're all ready,' is typical of many aspects of New Zealand life and although you may find it distracting in the consultation room, I now find it hard to interview people without their

family around. It also offers a wonderful chance for you to be able to confirm the things that the patient is telling you, as often the patient will be understating their own symptoms and you will only get the real truth from other family members.

- Eye contact is important in Pakeha society and implies interest and attention. In the Maori sense, to look your conversation partner in the eye puts the participants of the conversation in a position of conflict or opposition, and excludes others from the conversation. The patient gazing dreamily out the window is often listening very respectfully to the things that you have to say.

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- The Maori language has flowered in the last 15 years with the development of Kohanga Reo and Kura Kaupapa Maori schools. The greeting, 'Kia ora' is becoming very much a New Zealand greeting and you might well find it appropriate to let it slip into your own vocabulary.

- One needs to explain fully the necessity for diagnostic procedures and for treatment — how to take pills and when, who to go and see, and it is very important for you to outline what you as a doctor expect the outcome of this particular health intervention to be, so the patient can participate in monitoring this outcome.

Maori Medicine

Visiting a tohunga and the use of Maori herbal medicines has been restricted for the last 3 (urbanised) decades to those in the know; often rural people. In the 1990s, however, there is a large network of practitioners who prescribe and dispense Maori herbal medicine. Often the dispensing of this medicine will be accompanied

by prayer and intercession of both traditionally Maori and the Christian faith. While these modern dispensers of Maori medicine may not be the traditionally trained tohunga of yesteryear, they do have a large following, and are undoubtedly doing a lot of people some good. They are often also skilled psychotherapists, and are in contact with the client's family and relations, and can often address psychosocial issues more effectively than you and I.

Clinically, I find their treatments in inflammatory joint disease, asthma, and blood pressure have much to offer. I am, however, not an expert. I usually have no problems with my patients taking Maori medicine as well as mine. Occasionally a traditional practitioner has not thought likewise about my medicine, but generally there is opportunity for cooperation and exchange. These practitioners are much closer to their communities than you or I, and are deserving of our mutual respect. I often write them formal references as I would a surgeon, always getting a good response.

Mate Maori

It would be remiss of me not to mention an illness called Mate Maori. In the old days Maori believed illness was a result of wrongdoing or breaking of a tapu. The illnesses tend to be of a psychosomatic nature, often involving collapse, paralysis, pain, respiratory distress and various psychological or psychiatric manifestations. One should not immediately assume that such presentations should be sent to a psychiatric colleague (unless of course other circumstances rule it the only path) and consideration of further consultation within the family and community should be given. If you suspect that something of this nature is going on in the patient's illness, especially if the patient confirms your suspicions, then you should advise a visit to a kaumatua (an elder relative who looks after the family's wellbeing),

church minister, or the tohunga discussed above. You may or may not choose to continue your own part of the treatment, but you will often need to stay involved in a monitoring role. Real instances of these illnesses in modern times are not as numerous as they have been in the past and such clinical presentations are often a result of substance abuse. That does not, however, preclude the occurrence of this affliction which is as real today to those who suffer from it, as it ever was.

Death and Dying

Maori beliefs about death and dying are very different from the Pakeha view, as is the Maori way of grieving for the dead. Being aware of these differences will better position you to behave supportively to the Maori family in its time of grief.

When a Maori dies, the body is not immediately vacated by the spirit. The wairua (spirit) wanders at will, leaving and returning to the body for a period of 3 to 8 days. After this time is over it walks the beach called Te Oneroa o Tohe (Ninety Mile Beach) drinking from the sacred spring Te Wai-o-Rata and then to Cape Reinga, the northern point of Aotearoa. It is believed that the spirit dives off a pohutukawa tree located on a cliff at Cape Reinga, and down through the spot where the Pacific and the Atlantic oceans meet, to surface at an island called Manawatahi (a single breath). From here the wairua proceeds to the underworld (nothing to do with Hell) of Hine Nui-te-Po and thence to Hawaiki or Tawhiti, the ancestral spiritual home of the Maori.

A tangihanga will last 2 to 5 days, usually beginning the dawn after death. The Maori form of grieving is always expressed and when the body lies 'in state' upon the marae. The visitors will talk to it, recalling the person's past life, good points and failings, and will comfort the bereaved. The dead person is never left alone or unattended and gains strength and comfort for the coming

trip. The tangi is a complete therapeutic process with the greatest efficacy. The kiri mate (bereaved family) are embraced by the aroha of the people gathered and they are often able to resolve their grief effectively. A tangihanga is aroha at its height.

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After the burial is the hakari (feast). Here we see the turning point for the bereaved, towards the ongoing process of life. The hakari is shared with those who have come to support the kiri mate; it helps to sustain those who must now leave and often drive long distances home. The hakari is sacramental.

The last part of the tangi is called takahia te whare (tramp the house). This process returns a house of death to a house of life. With the aid of a karakia and water, the spirit is discouraged from returning home and encouraged on the journey to Hawaiki. The family is gradually weaned back to the living world by the close relatives, who will stay as long as it is necessary to do so.

When a Maori patient dies, your presence at the tangihanga is regarded as a tribute to the patient and the patient's family. Although it may be lost time, it will inevitably add credibility to you as a person in the eyes of the Maori community. If you want to go but do not know how, just ask one of your patients, or look in the paper for the funeral time and show up then. As a last resort – turn up at the marae gate and tag along with the next group who appear to know more than you.

Postmortems

While some of us in the health profession may think that postmortems are a form of quality control over clinical practice, Maori people certainly have no such thought. It is a highly undesirable and unnecessary bodily disfigurement and is to be avoided at any cost. The sanctity of the body is being invaded and the physical being is mutilated and interfered with.

Having said all that, Maori people have begrudgingly allowed postmortems to take place over the years and there is now no difference in postmortem rates of Maori and non-Maori. That change in behaviour, however, has not extended to quietly tolerating delays in releasing bodies after death because of waiting for a postmortem. One can see why there is an outcry when a body is kept in hospital over a weekend, or any other extended period of time, because there are the vital days of the wairua's wanderings and they are proceeding when no one is present to tangi (weep and grieve for) the departing person's spirit. There is also another point to consider. The longer a body is kept, the greater will be the financial burden placed upon the family concerned, for the visitors to the tangi must be fed – body or no body. It creates feelings of resentment and these are voiced openly at the tangi. The timely signing of death certificate, or the sorting out of an awkward delay will earn you heartfelt gratitude.

Summary

Maori health is an area of great challenge for purchasers, providers, and for the communities from which our people come.

We doctors may well become successfully and sensitively involved in the health care of Maori individuals and families, and some of us will form more formal relationships with Maori communities or organisations. Whatever role we play, our clients

have the expectation that we will know the basics, i.e. we know how to pronounce their names and at least some of the dynamics of everyday Maori family life.

As for developments in primary care by Maori communities; should we be awaiting them with trepidation, fearing for our jobs? I think not. My experience is not that Maori are setting up exclusive and separate health systems at all – far from it. They are either setting up small projects that will complement the general practice, if anything, increasing the doctors' clientele. The larger operations are setting up models of general practice and primary health care that will cater for clientele (of any ethnic group) that we doctors have probably not served well. After all, we all know how difficult it is for a patient to leave a doctor when a good relationship has been established.

Maori health initiatives are not a threat to general practice, they will simply become another part of the primary care equation and may well provide some interesting lessons for us all.

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