

Tauiwi¹ general practitioners explanations of Maori² health: Colonial relations in primary healthcare in Aotearoa/New Zealand?

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¹ Tauiwi is a Maori term for non-Maori New Zealanders.

² Maori are the indigenous people of Aotearoa/New Zealand

ABSTRACT

This paper reports initial findings from qualitative research investigating how general practitioners talk about Maori health. Transcripts of semi-structured interviews with 25 general practitioners from urban Auckland were subjected to critical discursive analyses. Through this process of intensive, analytic reading, interpretative repertoires – patterns of words and images about a particular topic – were identified. This paper presents the main features of one such repertoire, termed Maori Morbidity, that the general practitioners used in accounting for poor Maori health status. Our participants were drawing upon a circumscribed pool of ideas and explaining the inequalities in health between Maori and Tauiwi in ways that gave primacy to characteristics of Maori and their culture. We discuss the implications of this conclusion for relations between Maori patients and Tauiwi doctors in primary healthcare settings.

(129 words)

Keywords: Maori health status, primary healthcare, qualitative research, critical discursive analysis, interpretative repertoire.

Introduction

Despite improvements over the last fifty years (MoH, 1999; Pomare, 1980) the health of Maori remains far worse than that of Tauwiwi (non-Maori) New Zealanders (Davis, Beaglehole and Durie, 2000; Howden-Chapman and Cram, 1998; Pomare, 1995).

Commonplace explanations of these and other inequities overtly and subtly blame Maori for this state of affairs (Nairn and McCreanor, 1990, 1991; Wetherell and Potter, 1992) without necessarily considering the wider context in which health and other issues are embedded. Acknowledgement that the well-being (including health) of both Maori and Tauwiwi is established within the existing power relations of dominance and exploitation which originated in the European colonisation of this country (Durie, 1994; Walker, 1987) is rare among Tauwiwi.

Even more unusual would be an awareness of the crucial role that language plays in the reproduction of such a status quo (Billig et al, 1988; Wetherell and Potter, 1992). Sayings such as “actions speak louder than words” or “sticks and stones will break my bones...” underpin the Anglophone understanding that words are of lesser consequence than actions, an understanding that obscures the ubiquitous achievement of material outcomes through talk (Atkinson and Heritage, 1984). We argue from a constructionist position (Berger and Luckman, 1971; Gergen, 1990) that rather than being a neutral medium for the transmission of information, language is actively involved in the construction of meaning. As the pre-eminent form of social action, language has a frontline role in the maintenance of power relations both via mass media (Teo, 2000; van Dijk, 1989) and in inter-individual interactions (Seidel, 1985; Wetherell, 1998). Further, language shapes the context of its

own use constructing and transforming identities, relationships, knowledges and beliefs (Fairclough, 1992; Gavey, 1989). The study of language in action is thus a fruitful approach to understanding how power is manifest, implications for social practices (Edwards, 1995) and for social change.

The revelatory character of such analyses is evident in the growing body of studies of lay accounts of health and illness (Ogeden, 1997; Radley, 1999) and of strategies for coping with illnesses (Pollock, 1993; Radley, 1993). We see our project as contributing to the subset of health psychology research that, by analysing the discourses of professionals who work within dominant social institutions, demystifies the power relations that in part determine health care outcomes (Ingham & Kirkland, 1997; Malson, 1997; Ussher, 1992; 2001).

Our project is part of the broad "discursive turn" in social science (Gergen, 1990; Harre and Gillet, 1994) which includes the application of such approaches to health research (Ryan and Denz-Penhey, 1996; Radley and Billig, 1996). Underpinning this work is the growing understanding of the role of talk in negotiating, confirming and challenging social realities (Wetherell and Potter, 1992). Discourse analysis, the primary tool for this research, has been presented in detail by various authors (Parker and Burman, 1993; Potter and Wetherell, 1987). More recently these approaches especially where attached to a social change agenda have come to be known as "critical discursive psychology" (Edley, 2001). Such techniques are well-suited to the description of patterns or themes which are evident in talk on a particular topic (McCreanor, 1996). These patterns have been conceptualised as

interpretative repertoires (Potter & Wetherell, 1987; Wetherell, 1998) – clusters of ideas, argumentative forms and usages available to speakers. As such they can be considered as resources (Parker, 1992; Potter and Wetherell, 1987) for discussion of a topic, simultaneously legitimating and constraining what counts as valid argumentation. These resources are shaped by the ideological and discursive contexts in which they are developed and used (Billig et al, 1988). Description of the patterns helps to foreground and question assumptions routinely concealed by the everyday understanding of social practices (Antaki, 1989), informing discussions and debates about social change.

Primary healthcare is a set social practices in which language plays a central constitutive role. As such it is a rich site for understanding the social relations that characterise this important part of human experience. Some discursive dimensions of doctor-patient communications have been investigated and findings highlight the power relations between the two roles and the material effects of communication on medical intervention and outcome (Kaplan, Greenfield and Ware, 1989; Silverman, 1987; Simpson et al, 1991). In the area of intercultural interactions and health there is a literature which begins to link racial discrimination and negative health indices. For example Krieger and Sidney (1996) found elevated blood pressures among American blacks who take a passive stance on discrimination compared to those who challenge or resist unfair treatment. Other studies have corroborated this finding suggesting correlations between stressors relating to race relations at work (Dressler, 1990; James et al, 1984), in movies (Armstead et al, 1984) and in interpersonal confrontations (Kreiger, 1990), and health problems. While these studies are based in traditional individualising psychological paradigms, we argue that

such systematic effects are to be expected from articulations of power/knowledge through dominating discourses. If such effects are observable in these everyday situations it is likely that they could be active in many social scenarios including those of the primary healthcare consultation. While there is some published research that begins explore such relations for Aotearoa/New Zealand (Stanhope and Prior, 1976) we found only a skeletal literature which investigates the discursive resources upon which these relations are built within colonial societies (Hunter and Fagan, 1994; Paul, 1998).

Background

This paper presents part of a qualitative research project in which independently collaborating Maori and Tauwi teams (cf Cram, 1997; Cram et al, forthcoming) investigated the ways in which Maori users of primary healthcare services and Tauwi general practitioners talk about Maori health. The researchers decided that interviewing Maori and Tauwi separately on the topic of Maori health would provide a strong foundation for understanding the similarities and differences in the linguistic resources each group had to draw upon. It was agreed that cultural matching between researcher and participant would facilitate data collection and analysis; in the context of Maori/Tauwi relations in Aotearoa/New Zealand, intercultural exchanges are constrained on sensitive topics, including Maori health, by the anger, guilt and other emotions they engender. In building an interview database from these sources, we assumed that our participants would deploy the discursive resources salient to their arguments and positions in relation to Maori health. Our interest here is in what resources are drawn upon and the ways in which they are articulated

rather than on the content of the talk as a signifier of characteristics of the individual speaker. The goal of the research is not to judge participants on their positions in relation to Maori health, but to examine the discursive resources and the ways in which they serve to reproduce particular meanings and practices of salience to Maori health.

In this paper we begin our reporting by focusing on the description of one of ten interpretative repertoires³ drawn upon by our informants in their talk about Maori health. Such repertoires are assumed to reflect accessible and acceptable linguistic resources available to the speakers talking on the topic. These resources, because of their limited content and patterning of form, both enable and constrain discussion of the subject. For us a key interest was the extent to which our participants' interpretative repertoires could be used to explain, endorse, constitute or contest the commonplace interpretation of Maori health. We argue that the findings impact on outcomes of the interaction between Maori patient and Tauwi general practitioner and extend understanding of communication in such interactions.

Method

In this section we report on the data gathering and present our analytic methods in an effort to make our procedures as transparent and accessible as possible. As the Tauwi team we were responsible for the conducting of interviews with Tauwi participants, archiving and

³ The remaining repertoires are the subject of a further paper currently under preparation. They include resources focussed on Maori identity, gender, history, Maori health theory and practices, Maori health initiatives, style of working with Maori, Maori compliance and intercultural relations.

analyses of these data, and writing up the study in consultation with our Maori colleagues, Professor Linda Smith and Dr Fiona Cram⁴.

Having finalised the design, we carried out 25 semi-structured interviews with GPs from the Auckland urban area. Consultation through informal GP networks enabled us to ensure the depth and richness of the database by selecting participants of diverse experience, age and gender. In the interviews the researcher encouraged the participant to address the following topics:

1. Differences between Maori health and that of other patient groups.
2. National statistics on Maori health
3. Historical health status of Maori.
4. Traditional Maori health models and practices.
5. Differences in practices in working with Maori and other groups.
6. Gender differences in working with Maori.
7. Dimensions of Maori health

The interviews were audiotaped and transcribed verbatim, without punctuation, as this was suitable to the form of analysis planned. The transcription was checked against the audiotape by the researcher (TM), the participant given a pseudonym, and returned with the request that the participant read it with a view to accuracy, comfort with content and suggestions over masking that might be needed to preserve anonymity. A phone call

⁴ Professor Smith is Director of the International Research Institute for Maori and Indigenous Education at the University of Auckland. Dr Cram is Senior Researcher in the same organisation.

ensured that the participant was happy that the transcript be incorporated in the database. All participants agreed to the inclusion of their transcript and only four required (minor) amendments to the transcript.

Our data include the audiotapes and transcripts of the interviews (501 pages of text) which are evaluated and described using critical discursive analysis (Edley, 2001; Wetherell, 1998). This qualitative approach requires detailed readings of the body of transcripts in order to develop a systematic description of the ways in which language is deployed to establish and defend various positions on a topic. The analysis was worked primarily from the texts but frequent reference to the tapes was made in order to clarify ambiguities or to elucidate the nuances of what was said (e.g. pauses, inflection, irony). This process of disciplined reading of data establishes an overview of the data pool which facilitates the search for linguistic and rhetorical regularities and variations in the way diverse resources are marshaled to legitimate particular claims and counterclaims on a topic. Critical discursive analysis requires the researcher to attend to the detail – vocabulary, tense, choice of pronoun - and also to the more global characteristics of the text such as metaphor, imagery, rhetoric and meaning. The focus on subtle discursive process highlights assumptions, ambiguities, omissions and generalisations, in the explication the diverse themes apparent in the transcripts. Verbatim texts or sections of text which use such themes (at first rather loosely defined) are collated into files. The patterns of ideas, images, linguistic and rhetorical forms are clarified by further intensive reading of the files, allowing the researchers to describe and illustrate the content and function of the interpretative repertoires so constituted.

Results

The repertoire we called Maori Morbidity is derived from the data in which participants talk about disparities between Maori and Tauwi mortality and morbidity. Participants' explanations of Maori health profiles and their own personal experiences in working with Maori patients provided 43 excerpts from 21 of the 25 participants amounting to 61 pages of text. Participants' talk on Maori morbidity drew on conflicting patterns of ideas. One set downplayed any difference between the morbidity of Maori and Tauwi. Another highlighted the parlous state of Maori health and promoted a notion that Maori health is in crisis. While both sets of ideas can be drawn upon to take positions on the issue of Maori health, we restrict our presentation to the latter which was more common in the data.

Most participants endorsed research-based profiles of Maori morbidity and drew upon explanatory resources congruent with established medical model notions to account for them. We suggest that these resources can be considered as a multifaceted, interpretative repertoire. We found a number of distinct but complementary elements, any or all of which could be deployed for the purpose of explaining the current health status of Maori. In this section we present a series of excerpts which draw upon these diverse elements, along with our analyses of these data.

The importance of genetic factors in the health of individuals and populations was often stated, assumed or asserted on the basis of research literature and practical experience.

QUINN: I get the feeling that some of the bugs that are out there in this country have origins in Europe ... the immune system learns its responses over many generations and yet relatively speaking perhaps Maori children haven't had that same exposure to the same illnesses for generation after generation (p7-8)

Here, Quinn invokes the role of inheritance in the form of a lack of resistance to infectious diseases to explain Maori susceptibility. Maori have too short a history of exposure to European diseases for genetic adaptations to take place. While this is not overtly blaming, it constitutes Maori morbidity as a fact of nature, presumably to be accepted as regrettable but beyond the responsibility of the health professional.

Other participants highlighted the interrelation of genes and environments.

NOBLE: Yes I think they're [causes of Maori ill-health] multifactorial ... if you're looking at things like heart disease and diabetes then cultural dietary background ... there's a genetic predisposition there, there's genes involved and I think there's also the effect of socioeconomic status as well (p2)

Noble makes explicit the assumption that health is the product of interactions between genetics and environment, where in this talk, environment includes cultural and socioeconomic influences. In our data base overall, this notion of inheritable resistance and genetic predisposition to various conditions was the main explanation offered for Maori morbidity in relation to both infectious and non-communicable disease. As a discursive resource these explanations locate significant causal factors of Maori ill-health as essential characteristics of Maori individuals and populations.

Of the environmental factors drawn upon by participants the two key variables, socioeconomic status and culture, are commonly depicted as overlapping and complex. Socioeconomic status is seen to have both direct and indirect effects on health.

NOBLE: I think there's also the effect of socioeconomic status as well ... its a lot harder to eat correctly if you're on a limited budget than it is when you've got access to fruit and more expensive things out of season in terms of maintaining the diet (p2)

Diet provides a clear example of the impact of low socioeconomic status. Poverty imposes a restriction in range and quality of foods so nutrition and health suffer. The implied reliance on cheaper, poor quality foods, can impact directly on medical conditions or contribute to dietary imbalances which pre-dispose the individual to ill-health. Other participants referred to rental accommodation, mobility of families, and the bleakness of life close to the poverty line as other impacts.

The second major environmental factor is culture in the broadest sense. In these data culture includes contemporary social organisation as well as elements of what might be termed traditional Maori culture. Maori are said to operate from a family-based collaborative culture which places the welfare of the group above that of the individual and therefore involves priorities that are different from those of other population groups. Participants stressed negative consequences of such social organisation including an inability to fit in with Tauwi systems.

RODGERS: I feel maybe one of the things is the way they think of health and disease and going to the doctor ... maybe access is another thing being things like transport money social things ... if you've got a large family or you're living with people that you've got lots of commitments to you can't just say 'well I've got a doctor's appointment' ... I mean we get lots of cancellations ... they'll come in later and say 'well I couldn't make it that day because I had to take my Auntie to so and so' you know ... they're not as nuclear so they have a lot more commitments with the extended family and those things are more important than the doctor's appointment ... and I don't know if it's because of rental accommodation the fact is that Maori ... families seem to move more so you don't often get them where they've had one same family doctor for years so the family history and notes [are missing] ... (p13)

Here, Rodgers works together several perceived cultural features of Maori social organisation any of which may impact on health. Prioritising the family over the doctor, residential mobility, lack of continuity of care and absence of medical history are manifestations of "the way they think of health". Again the problem is located with Maori and in this instance in an aspect of Maori worldview. Aside from the mundane effects noted by Rodgers, other participants noted major impacts of socialisation within contemporary Maori cultural settings. Cycles of neglect and abuse are a key example.

HENNESSEY: I think a lot goes actually back to what the generation has done before ... like you've got a generation that will introduce your younger generation to alcohol and cigarettes very young like before five sometimes ... I think the recurrent

ear and throat infections in children that cause a degree hearing problems relate to learning difficulties which relate to low school performance and early dropping out of school which obviously leads to unemployment ... and most of the people that I see struggle like that are people who are unemployed ... but they spend their time drinking and smoking ... a lot of it is the women ... because the women have got the highest rate of lung cancers ... the men tend to end up smoking [being] violent [abusing] alcohol ... I think a lot goes back to the breakdown of the basic nuclear family or the family structure (p17)

Hennessey captures the sense of the health implications from culture lost. The young are raised in an environment in which because of the damage to “the family structure”, levels of care are reduced and levels of danger are raised. The example of hearing loss and its consequences which inevitably reproduce the cycle is but one of the diverse negative possibilities which afflict each generation in turn. Equally problematic, according to this account, is the early onset of tobacco and alcohol use with different but high probability outcomes for men and women. Similar understandings of the problems of getting Maori health issues onto a preventative footing were expressed by other participants. Tobacco use was a common concern.

FULLERTON: if you're depressed in the first place then its difficult sometimes ...if smoking is a pleasure to have to give it up merely for the benefit of ones supposed lung health when in fact it might actually make you feel better at the time ...

so its a catch 22 too for a lot of them I think just letting go of one thing on the in the hope that they will feel better in a in another way (p3-4)

Fullerton argues that Maori are alienated from the practices of self-care because those seem to exacerbate their already dire immediate reality. She interprets this as a paradoxical situation for Maori and is thus able to understand why tobacco use might continue in spite of the dangerous side effects.

These facets of the cultural aspect of environmental influences on Maori health cover the cultural spectrum from the seemingly trivial behavioural traits observed firsthand by doctors, to Tauwi representations of Maori philosophical positions. A number of participants raise positive aspects of culture such as spirituality and supportive extended family networks. However such claims are matched by rebuttals in the talk of other participants that marginalise or negate that positivity in relation to the practice of medicine. The overall impression is that Maori culture is a burden to Maori as they strive toward better health

From our analyses of all of the interview data relating to Maori ill health, we have drawn together a description of the common elements of this multifaceted repertoire which we can now present as a whole. Fundamental to the repertoire is the notion that the experiential view of Maori health from Tauwi primary healthcare is strongly congruent with the position indicated by nationally collated data for Maori, and on this basis that Maori health is in crisis. Maori are more commonly and more severely afflicted by the

broad range of acute and chronic conditions that affect the population as a whole. A second central element is the idea that Maori health is a product of the constitution and behaviour of Maori people, and of Maori social organisation. The differential between the health of Maori and that of the rest of the population turns upon interactions between genetics and environment (primarily socioeconomic status and culture) in a conventional medical model analysis. Peripheral to these ideas is a position in which uncertainties over Maori identity and the confounding effects of socioeconomic status are the basis for the idea that there is no significant difference between Maori and Tauwi in population health status.

We have incorporated both sets of ideas despite their apparent contradiction because both are available for accounting for Maori health status (albeit in different ways) and both focus on the constitution and behaviour of Maori people, and on Maori social organisation. Whichever set of ideas is drawn upon, the effect is to minimise the significance of the historical and political contexts of Maori health.

Discussion

Qualitative research of the kind reported here has little to say about prevalence or the generality of its findings in populations beyond its participants. Should there be concern about the generality of the repertoire we have reported on here this could be assessed through a more substantial survey of practitioners. If the repertoire we have described is a widely used resource among GPs this is a cause of concern as it will inform and shape actual interactions between Maori patients and their (usually) Tauwi doctor. However

our findings are consistent with other studies of the language of the powerful (Ingham & Kirkland, 1997; Malson, 1997; Ussher, 1992; 2001) in that the identified interpretative repertoire enables explanations of Maori morbidity that dissociate the phenomenon from relations of domination.

Further such Maori focussed constructions of Maori health are likely to create adverse effects on the communication between doctor and patient. As we already know about the impact of doctor-patient communication on health (Silverman, 1989; Simpson et al, 1991) and links between discrimination and health (Kreiger & Sidney, 1996) we argue that our findings have serious implications for Maori health outcomes from primary care. There are consequent implications for education and training of primary healthcare workers and for development of policies on Maori health.

We notice that our participants' explanations of the state Maori health do not relate in any way to widely available Maori theories and conceptualisations of health (Durie, 1995; Pere, 1997). These holistic, communitarian frameworks emphasise social, cultural and economic interconnection as the basis and context of individual health so that such factors take a crucial role in the explication of Maori health status. Our interpretation of Maori theory is that particular historical political processes and social contexts should be interrogated for their contributions to the established power relations within which the interactions and practices of primary healthcare are located. In the case of Aotearoa/New Zealand, such perspectives invite us especially to consider the colonial context of healthcare services in general.

Already to hand are the writings of numerous Maori academics that make clear the profound negative impact of 200 years of colonisation upon all aspects of Maori life (Smith, 1992; Smith, 1999; Walker, 1990) and especially upon Maori health and well-being. As well as diverse sources of introduced mortality and morbidity, Maori have experienced open warfare, land confiscation, destruction of their economic base, legislative injustice, social discrimination, and racism. These multiple assaults have resulted in severe disruption of diverse Maori cultural forms and institutions across the board. Maori have been effectively reduced to the status of second class citizens in their own country as reflected in the differential health statistics that are the subject of the participants' talk in this paper and other indicators such as wealth, education and social status. In the context of Maori health, the marginalisation of the cultural infrastructure that once cohered around Maori healing and medical practices, amounts to damage which can only have compounded the more obvious losses.

We argue that the resources of the Maori Morbidity repertoire lend themselves to explanations of the poor health status of Maori as a function of being Maori and so naturalize a situation that is ethically, socially, economically and unacceptable. In the privileging of such accounts what is achieved is the marginalising of the competing explanations of Maori health and morbidity based in the social and political contexts and processes referred to above.

We believe our findings have an intensely practical significance. Communication between doctor and patient is increasingly regarded as central to the practice of primary health care, directly and indirectly determining the outcome and therefore the efficacy of such enterprises. As far as we know studies of actual interactions between Maori and their GPs have not been done, but Maori research colleagues on the present study conducting interviews with Maori users of primary healthcare services have gathered data that raise serious concerns about the perceived beliefs of the participants' doctors concerning Maori and Maori health.

We argue that ideological resources and the discursive practices which flow from them (as highlighted in this research) that identify the causes of disparities in Maori health in characteristics of Maori or Maori social organisation stand in direct contradiction of the findings and recommendations of Maori scholarship and thinking. This imbalance needs to be addressed and will require work in both theoretical and applied fields that addresses the context and processes within which Maori health is constituted. Of critical importance to this effort will be the consideration of the paradigms within which doctors operate, and analyses of the power relations that underpin the everyday interactions of medical practice.

On the Maori side efforts are well under way to develop the kinds of ideological resources that are needed to support the rejuvenation of Maori society, bring the health gains that are needed, and produce the kind of equitable society to which so many in this country aspire. In particular Durie has developed elegant models of the necessities for

Maori health and the development of Maori in all areas including health which make explicit the critical need for Maori to feel secure in their traditions and worldview. (Durie, 1997a). Te Pae Mahutonga (Durie, 1997b) stresses that the health of Maori depends on an intact, composite and holistic conception of their place in the world that rests on cultural, economic, spiritual and social foundations enabled by meaningful autonomy and appropriate leadership. These frameworks seem entirely congruent with emerging policy and practical trends toward “by Maori, for Maori” health service provision and together these developments represent a considerable challenge to the universalist claims of Tauwi primary healthcare.

Meanwhile the current research project will continue the work of analysis and critique of Tauwi discourses surrounding Maori health. Subsequent papers will present an overview of all of the interpretative repertoires encountered to date. In addition we will be able to offer a sharper focus on particular aspects of discourses of primary healthcare such as those in the area of compliance which constitute patients in ways that allocate blame for poor outcomes and justify doctors’ practices.

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