‘A kind of ritual Pākehā tikanga’ - Māori experiences of hospitalisation: A case study

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Abstract

Minimal literature exists relating to the experiences of Māori within the New Zealand public hospital system. Māori are highly represented in morbidity and mortality statistics and are high users of the secondary health care system. A Case Study methodology with a Māori centred approach was used to describe Māori experiences of hospitalisation. Multiple sources of evidence were gathered, including participant interviews, statistical data from the New Zealand Health Information Service, and international literature relating to indigenous experiences of hospitalisation. Eleven people (nine female and two males) identifying as Māori, of various iwi (tribal) affiliations and from a range of regions, participated in the interviews. All participants had either been admitted, or cared for by a family member who had been admitted to a medical or surgical ward in a public hospital anywhere in New Zealand within the last 15 years. Participants were aged between 20 to 75 years. All interviews were audio recorded, transcribed and then thematically analysed. A retrospective interrupted time series design was used to examine length of stay for Māori patients receiving treatment in the secondary medical and surgical setting, from 1989-2004. The data included the records of all medical and surgical discharges for Māori and non-Māori from the New Zealand public hospitals. Medical and surgical admissions were screened to include those over the age of 17 years and who had a length of stay greater than 1 day and less than 90 days. From the analysis of all the data three key interpretations emerged: 1. Māori are marginalised within the mainstream health system. 2. Māori believe that the hospital environment is not conducive to healing. 3. Māori experiences in hospital contribute to their decision to leave as soon as possible. The recommendations include the integration of more culturally acceptable and appropriate interventions within secondary and tertiary health services,

and a review of the effectiveness of cultural safety education in practice and inclusion/revision of the cultural competence for all health care workers.

Preface

Ko Tainui te waka
Ko Pirongia te maunga
Ko Kāwhia te moana
Ko Ōpārau te awa
Ko Te Matapihi te puna
Ko Rangiahua tōku papakainga
Ko Waipapa tōku Marae
Ko Ngāti Puhiawe me Ngāti Horotakere ngōku Hapu
Ko Ngāti Hikairo tōku Iwi
Ko Pipi Barton ahau

Kāwhia Moana, Kāwhia Kai, Kāwhia Tangata.

Ko Kaiewe te whenua

Nā Whaea Mere Gilmore

(Ngāti Hineue, Ngāti Puhiawe, Te Whānau Pani, Ngāti Horotakere, hapū nō Ngāti Hikairo)

E rere rā koe i runga tō maunga
Ko Pirongia tō maunga
Ngā nohotanga ā ō tupuna
Mihi atū kī ā rātou e

Rere mai rā koe i runga te whenua
Ko Kaiewe te whenua
Ngā haeretanga ā ō tūpuna
Tangi atu ki a rātou e

E huri tō kanohi ki te tāngaengae
Ko Pekanikau tāngaengae
Ngā okiokinga ā ō tūpuna
A nunui mā, a roroa mā
Whakamihia te puke tapu rā

Mihi atu rā ki te awa e rere rā
Ōpārau, kua kite rā ia i ngō tūpuna
Me ngā uri o Puhiawe, o Hineue

E rere rā koe tō mātou tūpuna wai
Puta atu rā koe
Ki te moana o Kāwhia

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Glossary of Terms

A
Aotearoa- Indigenous name of New Zealand
Aroha- Love
Awhi- Help

H
Hapū - Sub-tribe

I
Iwi- Tribe

K
Kaupapa- methodology; subject
Kākano- seed
Kanohi kitea- known face
Kawa- customs

M
Māramatanga- enlightenment
Mahi- work
Mana- prestige
Mātauranga- knowledge

P
Pākehā- New Zealander of European descent/origin
Paru- dirty

R
Rangatiratanga- sovereignty
Rito- centre

T
Te reo- Māori language
Tikanga- practice
Te Tiriti o Waitangi- Treaty of Waitangi (Founding document of New Zealand)

W
Whakapapa- genealogy
Whānau- family
Whanaungatanga- relationships and family connections
Whakawhiti kōrero- discussion

Chapter 1

INTRODUCTION

Māori continue to experience high morbidity and mortality when compared to non- Māori New Zealanders (MOH, 2006; Robson & Harris, 2007). But despite this, when Māori enter hospital for a medical or surgical intervention, they are more likely to be discharged earlier than non-Māori. (Davis, et al., 2006; Wilson et al., 2008). The differences in the average length of hospital stay (ALOS) data and the observations of whānau receiving treatment as inpatients have led to this research study. Māori experiences within mainstream health services in New Zealand have rarely been investigated. Understanding what occurs when a Māori patient is admitted to hospital is a key aim of this research project. The narratives of Māori provide insight into the reasons why Māori experience a shorter lengths of hospital stay. Therefore the research question asks: What are Māori experiences of hospitalisation?

Māori and hospitalisation

Minimal literature relating to Māori experiences of hospitalisation exists despite the high utilisation of hospital by Māori. Historically Māori have been reluctant to go to hospital, much of the concerns of Māori were centred on the limited visiting hours, suspicion of hospitals and western medicine (Buck, 1966). Māori opposition to hospitalisation was common and when a few could be persuaded, it was considered a last resort. Cultural preference meant that a sick person was more likely to see a Tohunga rather than a doctor (Lange, 1999). Durie (2001) explained that during the 1970s there was a increase in Māori admissions to psychiatric hospitals, and he proposed that this was likely due to a combination of factors such as higher utilisation of services by the increasingly urbanised Māori population, changes to the ethnic identity recording and the introduction by hospitals of a more systematic process for recording ethnicity.

The trend changes in Māori hospitalisation rates are relevant in relation to possible changing Māori attitudes towards hospitalisations today. Reid, Robson & Jones (2000) suggested that Māori access health services differently, over utilising secondary health services while under utilising primary and tertiary health services (Bramley et al., 2004; Ellison-Loschmann & Pearce, 2006). This study hopes to determine that despite the high admission rates whether the experiences and concerns of Māori regarding hospitalisation in the past still have some resonance today.

Māori health status

There had been significant improvements in Māori health status generally in the 1950s to 1970s, but major social and economic restructuring by the government since that time has seen no further improvement in Māori health (Awjani, Blakely, Robson, Tobias, & Bonne, 2004; Blakely, Tobias & Atkinson, 2008; National Advisory Committee on Health and Disability, 2002). Following World War II up until the late 1970s, Māori were beginning to experience equalities of income with non-Māori, but following the Labour government's economic restructuring during the 1980s, Māori income inequality increased markedly (Howden-Chapman & Cram, 1998), the consequences of which continues to be exhibited in Māori predominantly occupying the lower socio-economic population of New Zealand. Research indicates that people in the lowest socio-economic groups consistently have the poorest health; a causative relationship between health and socio-economic conditions has been well established

(Awjani et al, 2003; Durie, 2001; Howden-Chapman & Cram, 1998; National Advisory Committee on Health and Disability, 2002; Robson, 2004; Te Puni Kokiri, 2000) The increased morbidity and mortality experienced by Māori is a direct result of their poorer social and economic status in New Zealand society (Blakely, Tobias & Atkinson, 2008; Howden-Chapman & Cram, 1998; Ministry of Health & University of Otago, 2006). Following the economic reforms of the 1980s, the government implemented major health reforms in the 1990s - these health reforms created an even wider gap in health status and outcomes for Māori.

Mortality rates were likely to increase with increasing socio economic deprivation, Māori were disproportionately represented in most deprived areas and therefore at higher risk of death. Cardiovascular disease being the most common cause of death, accounting for a third of all Māori deaths. Just over a quarter of Māori deaths are caused by cancer, 8% of Māori deaths are due to respiratory disease and accidents, 7% due to diabetes and 3% due to suicide.

Māori experience poorer health outcomes in all areas of health but are most obviously in heart disease, cancer and diabetes statistics. The prevalence of heart disease among Māori is 1.5 times that of non-Māori and ischaemic heart disease rates were more than 2.5 times that of non-Māori (Curtis, Harwood, & Riddel, 2007). The statistics do not fare much better when examining cancer rates for Māori. Māori have a higher registration rate for all cancers than non-Māori, yet Māori have a significantly higher risk of death from cancer after diagnosis than non-Māori for many cancer types. (Cormack, Purdie, & Robson, 2007). Rates of diabetes are almost three times more common in Māori than non-Māori, with the 45-64 year age group experiencing rates nine times higher than non-Māori for the same age group (Harwood & Tipene-Leach, 2007).

With increased socio-economic deprivation and poorer health outcomes Māori experience higher rates of hospital admissions. In 2005 just over one in eight Māori and just under one in eight non-Māori people were admitted to hospital, with an average of 1.7 admissions each among Māori and 1.6 admissions among non-Māori (Robson, Robson, Harris & Purdie, 2007). Because Māori are disproportionately represented in most deprived areas, Māori are at higher risk overall of hospitalisation than non-Māori. With the exception of children under the age of 15 years, Māori public hospitalisation rates were higher than non-Māori rates at the same level of deprivation, in each age group (Robson, Robson, Harris, & Purdie, 2007).

The literature continues to provide many examples of the major inequities that exist within New Zealand health services (Awjani, Blakely, Robson, Tobias & Bonne, 2003; MOH, 2006; National Advisory Committee on Health and Disability, 2002; Robson & Harris, 2007). A retrospective cross-sectional assessment examining the quality of hospital care received by Māori patients (Davis et al., 2006) found they accounted for just over 15% of all admissions and were on average younger, more likely to be from deprived areas, and more likely to be admitted with co-morbidities. This assessment also found that once in hospital Māori not only experienced a shorter length of stay than non-Māori but 14% of Māori admissions were associated with an adverse event, compared with 11% of non-Māori admissions. Davis et al. (2006) explained that despite a predominately publicly funded hospital system, hospital care received by Māori is marginally poorer than that received by other New Zealanders.

When reflecting on the research question, *“what are Māori experiences of hospitalisation?”,* and considering how these experiences might impact on the average length of stay, it is necessary to consider all possible influences on Māori health status. Therefore, having discussed the historical and socio-economic factors that influence Māori health outcomes, it is necessary to consider what other likely range of factors may contribute to Māori health outcomes and how these factors may not only impact on the health of Māori but also how these factors may contribute to rates of hospitalisation and, subsequently the average length of stay. The following discussion considers some of the current theory (Durie, 2001).

Differing worldviews

The western biomedical model dominates mainstream health services in New Zealand. Therefore it dominates the way health and illness is viewed and the delivery of treatment. Health perspectives of indigenous people do not tend to fit into the simplistic western scientific understanding of health. Māori understandings of health have consistently demonstrated a holistic view that is grounded in Māori ways of knowing and viewing the world. Health does not exist independently of other facets of the person, but as part of a myriad of systems that interconnect and are dependent on internal and external forces including whānau (family) (Barton & Wilson, 2008; Marsden, 2003; Wilson, 2004; Wilson 2008).

Cultural appropriateness of services provided

Debate exists amongst Māori health service providers that the Crown does not see Māori health in terms of the needs of Māori communities; they instead see health as something relative to Pākehā health (Caccioppoli & Cullen, 2005; Reid et al, 2000). Critics support this view and state that there is little wonder that the health system serves Pākehā better than it serves Māori, it is a “by Pākehā for Pākehā” system (Caccioppoli & Cullen, 2005) Reid et al. (2000) further suggests that attempts to engage with ethnic groups are often preoccupied with cultural needs that provide ‘decorative rather than functional value’, suggesting that services based on cultural deficit policies fail to change outcomes, and when this is determined it is likely that the service blames the client group rather than the relevance of the service being provided, therefore perpetuating stereotypes.

Cultural differences in values and aspirations

Over the last 150 years, the traditional health beliefs of Māori have progressively been challenged by a predominantly western focussed Euro-centric worldview. Lange (1999) states that pre-European Māori traditional understanding of health and illness were based on an ancient Māori worldview and made no distinction between “religion” and “science”. He further explains that Māori had no concept of “science” and their “religion” permeated their every action; Māori saw the workings of the supernatural in every aspect of their natural world. These traditional values and beliefs regarding health continue to have some resonance today. Ellison-Loschmann & Pearce (2006) discusses the increasing evidence to suggest that Māori and non-Māori differ in terms of access to both primary and secondary health care services (Ellison-Loschmann & Pearce, 2006).

Discriminatory practices of staff

Discriminatory behaviour in the provision of services is another influence on Māori health outcomes (Durie 2005). International literature proposes that racism contributes to the ill-health of migrants, ethnic minorities and indigenous peoples. The racism experienced by minority groups negates wellbeing, adversely affecting physical and psychological health (Nairn, Pega, McCreanor, Rankine, Barnes, 2006). The same is occurring here in New Zealand, for example Māori are 10 times more likely to experience multiple types of discrimination than compared to others. The racism experienced by Māori contributes to health losses and leads to inequalities in health between Māori and Europeans (Harris et al., 2006).

Aims of research

The research aims are to understand:

1. Māori health related values, beliefs and experiences
2. the Māori experience of hospitalisation
3. how Māori experiences of hospitalisation may relate to their length of hospital stay

Participants in this study identified as Māori, and were either an inpatient in a medical or surgical ward of any hospital in New Zealand or were a family member of a Māori who has been an inpatient in a medical or surgical ward of any hospital in New Zealand between 1989 and 2004. A Case Study research methodology was used together with a Māori centred approach. Case study research designs are suited to conditions that focus on experiences within a real life situation. A Māori centred approach to research considers ideas such as Māori control, enablement, and integration of the research process (and will be discussed further on page 40). The research outcomes have implications for nurses and other health professionals seeking to work with Māori within the health sector.

Overview of chapters

Māori experiences of hospitalisation will be described in the following chapters, by bringing together all the data that will help to understand the phenomena. Chapter 2 will investigate existing literature relating to Māori health status and hospitalisation. Firstly, a brief examination of the historical context of Māori health will be discussed, from the time of the arrival of the European until today. Then current Māori health status will be described and statistics relating to morbidity and mortality presented, followed by a description of the determinants of Māori health outcomes, examining factors that have some influence on the health of Māori. This will be followed by a discussion on international literature relating to indigenous health outcomes in Australia, Canada and the USA. The chapter will then describe the history of Māori and hospitalisation and reflect on recent literature relating to Māori and hospitalisation; and finally will conclude with a discussion on Nursing and Māori both historically and today.

Chapter 3 will discuss the methodology that was used to develop this research study. First, a description of the methodological principles of Kaupapa Māori research, the foundation of Māori centred research, then a definition and description of the methodological principles of Māori centred research. Case study methodology will then be examined in relation to this study, describing the methods of data collection and analysis. Finally the chapter will conclude with a description of the ethics and limitations of the study.

Chapter 4 will examine the findings from the qualitative and quantitative data. It begins with a description of the demographic profiles of the participants. The narratives provide two main themes. Theme one, 'A Foreign Environment' describes the participants’ perspectives of hospital, and comprises of three sub-themes. Theme two describes ‘whānau caring for whānau and has four sub-themes that will examine some of the experiences of care in hospital and provide the rationale for why Māori prefer to have their family care for them in hospital. Each sub-theme is discussed and supported by dialogue taken from participant interviews. Quantitative findings are also described, using information gathered through the New Zealand Health Information Service. Findings relating to the average length of stay will be discussed.

Chapter 5 will provide the analysis of all the data. Findings from the participant interviews will be discussed and the similarities of these findings to international indigenous literature will be described. Finally, through triangulation three key interpretations will be identified and discussed.

Chapter 6 will provide a conclusion to the study, by briefly summarising each chapter and discussing the implications of the findings on nursing practice and health care provision and recommendations will be suggested.

Conclusion

Although there exists a wide variety of literature exploring the probable barriers to health care for Māori, there exists very little information about the individual health experiences of Māori or their experiences of hospitalisation and consider the possible influence these experiences may have on their average length of stay (ALOS). Understanding what occurs when a Māori patient is admitted to hospital is a key aim of this research project. It is hoped that through examining Māori experiences of hospitalisation insight will be gained into the phenomena and a better understanding of the possible reasons why Māori experience a shorter stay in hospital when compared to non-Māori.

Chapter 2

LITERATURE REVIEW

Introduction

Literature relating to Māori experiences of hospitalisation is noticeably absent within health publications. Although there are large quantities of literature relating to cultural safety, and minority population health disparities, literature relating specifically to Māori is not vast. Publications describing Māori and their experiences of the health system in New Zealand, either from an individual or family perspective is sadly lacking throughout the literature. Therefore this literature review will begin by providing a brief historical overview of Māori health and attitudes to hospital at the turn of the 20th century. Following the historical discussion, a contemporary view of Māori health will be provided along with a description of the determinants of Māori health. A brief discussion will then ensue on the state of indigenous health internationally in relation to Māori health, and then regarding hospitalisation and Māori. Finally a brief historical and contemporary overview of nursing and Māori health will be provided.

An extensive search of the literature was undertaken using the Massey University library catalogue and databases. CINAHL, ERIC, Ovid and Medline were the predominant databases used, as well as Web of Science. Searches of related health websites such as the Māori Health Commission, Te Puni Kokiri (The Ministry of Māori Development) and the Ministry of Health were also undertaken, along with a thorough search of theses throughout all the universities in New Zealand. Key words used included Māori, indigenous, aboriginal, native, First Nations, Inuit, Native

Americans, Native Hawaiian, health, illness, hospital, hospitalisation, average length of stay, ethnicity, inequalities, disparity and nursing. Combinations of key words were used also, such as indigenous health, Māori nursing, indigenous and hospital, aboriginal and hospital, indigenous disparities.

Māori Health History

Prior to the arrival of European people (Pākehā), Māori were healthy with very little illness and disease (Buck 1966; Papakura, 1938). Mortality among children was low and there were no records of endemic or epidemic diseases. Diseases such as typhoid, tuberculosis, measles and venereal disease were unfamiliar to Māori when introduced after European contact (Buck, 1966). Familiar interventions used by Māori to assist with the recovery of the ill were found to be of little use when used to treat the diseases brought to New Zealand by the Pākehā. Having lived in relative isolation from the rest of the world over the centuries, Māori lacked natural immunity, therefore great numbers of the Māori population succumbed to the ravages of disease; increasing mortality saw the reduction of the Māori population.

As a result of high mortality rates and the declining population, by the beginning of the nineteenth century it was believed that Māori were heading toward extinction. Māori believed they would die out, a view accepted by Pākehā. In 1774 during Captain Cook's second voyage to New Zealand, the Māori population was thought to be around 100,000, by 1896 the Māori population had reduced to a little over 40,000 (King, 2003; Lange, 1999). These population estimates fuelled Pākehā beliefs that Māori were a dying race, and thought to be declining in such numbers that John Logan Campbell the former Mayor of Auckland made provisions in his will for the erection of a monument on the summit of Maungakiekie (One Tree Hill) to memorialise the “dying” Māori race. (King, 2003)

By the early 1900’s Māori mortality rates increased further due to the 1918 influenza epidemic that spread throughout the country. Māori demonstrated less resistance to the epidemic than Europeans. Mortality estimates at that time are thought to seriously under-represent the true effect of the influenza epidemic. Later examination of the death rate suggests that Māori fatalities were actually estimated to be four and a half times higher (King, 2005), and possibly as much as seven times higher than Pākehā (Lange, 1999). By the 1950s Māori mortality rates began to improve as exposure to European diseases for over 100 years helped develop natural immunity. Māori life expectancy continued to increase during the 1960s and 1970s. Blakely & Robson (2003) suggested that if these trends continued through the 1980s and 1990s Māori would have experienced very little difference in life expectancy by the year 2000.

Māori health status

Evidence suggests that the economic and social reforms of the 1980s and 1990’s had a significant effect on Māori health status. Of note there was little decrease in Māori mortality rates over the two decades despite a steady decline in non-Māori mortality rates. (Blakely, Ajwani, Robson, Tobias, & Bonne, 2004; Blakely, Tobias, & Atkinson, 2008). During the economic reforms of the 1980s, Māori rates of unemployment went from being the same as, to three times that of non-Māori. Māori were more likely to experience lower incomes and poorer living conditions (Blakely et al., 2004). The major structural changes that occurred at the time of the economic reforms in New Zealand coincided with no further improvements in Māori health (Collings & Ellis, 1997; Durie, 2001; Howden-Chapman &

Cram, 1998; National Advisory Committee on Health & Disability, 2002; Robson, 2004; Te Puni Kokiri, 2000).

Maori health was further affected by the health system restructuring of the 1990’s. Gauld (2003) recounted how New Zealand experienced four different health sector structures in a decade, each change occurring following general elections in 1990, 1996, and 1999. McCloskey and Diers (2005) demonstrated how the chaotic environment caused by governments’ restructuring of the health system resulted in a decline in the overall quality of patient care. Early indications from unpublished research by Wilson et al. (2008) suggest that the negative effects of the 1990s health system reforms on nursing adversely contributed to higher rates of some Outcomes Potentially Sensitive to Nursing (OPSNs) for Maori particularly in the medical hospital setting.

The social and economic changes that occurred in the decades leading up to the turn of the century continued to have on going effects on Māori health which are evident in health disparities that occur between Māori and non Māori today. During 2000 to 2002 the major causes of death for Māori were all chronic diseases with ischaemic heart disease the leading cause of death, followed by lung cancer, diabetes, chronic obstructive pulmonary disease and cardio vascular disease (MOH, 2006). During 2000 to 2004 cardiovascular disease was the most common cause of death among Māori, accounting for a third of all Māori deaths. The prevalence of heart disease among Māori was 1.5 times that of non-Māori and ischaemic heart disease rates were more than 2.5 times that of non-Māori (Bramley, et al., 2004; Carr, Robson, Reid, Purdie & Workman, 2002; Riddell, 2005)

The statistics do not fare much better when examining cancer rates for Māori. Māori have a higher registration rate for all cancers than non-Māori, yet Māori have a significantly higher risk of death from cancer after diagnosis than non-Māori for many cancer types. (Cormack, Purdie, Robson, 2007) The most common cancers registered for Māori women were breast, lung, colorectal, cervical and uterine. The registration rates for Māori women for breast cancer are 1.3 times that of non-Māori women, but the breast cancer mortality rate was twice that of non-Māori (Curtis, Wright, & Wall, 2005). For cervical cancer, Māori women have a registration rate twice that of non-Māori; however the mortality rate was four times that of non-Māori women. The leading cause of death for Māori women was lung cancer, with a registration rate of 4.5 times that of non-Māori women, and mortality rate five times that of non-Māori (Harwood, Aldington, & Beasley, 2005).

The most common cancer registration and causes of death for adult Māori men is lung, prostate, colorectal, stomach and liver. Lung cancer registration and mortality rates for Māori men are three times that of non-Māori. When compared to non-Māori men, Māori male mortality for prostate cancer is twice the rate; for liver cancer it is six times higher; and stomach cancer mortality is three times higher. For many cancers the rate ratio for Māori compared to non-Māori was higher for mortality rates than for registration. (Jeffreys, et al., 2005; MOH, 2006)

Cardiovascular disease presents a similar picture, with Māori experiencing two and a half times the mortality rate of non-Māori, stroke mortality was nearly twice as high, and heart failure mortality three times as high. During 2000 to 2004 Māori males aged between 45-64 years had a death rate from ischaemic heart disease that was 3 times that of non-Māori males. Māori females of the same age group had a death rate that was 4.4 times that of non Māori over the same period (Curtis, Harwood & Riddel, 2007)

Rheumatic heart disease mortality was more than eight times higher than non-Māori rates. Chronic obstructive pulmonary disease Māori mortality rates are three times that of non-Māori (MOH, 2006). Diabetes is where significant health inequalities are most obvious. Rates of diabetes are almost three times more common in Māori than non Māori during 2000 to 2004, with the 45-64 year age group experiencing rates nine times higher than non-Māori for the same age group. Hospitalisation rates due to type 2 diabetes are 4 times higher and mortality rates seven times higher. Disparity in mortality is highest in the 45-64 year age group, with Māori women dying at 13 times the rate of non-Māori women and Māori men dying at 10 times the rate for the same age group. Māori are much more likely to experience complications from diabetes than non-Māori (Harwood & Tipene-Leach, 2007; Kerr, Gamble, Doughty, Simmons, & Baker, 2006).

Although Māori health status has improved over the last 100 years, Māori and non-Māori disparities in health are evident in almost every disease category (Durie, 2001). Māori continue to experience poorer health outcomes and lower levels of intervention than non-Māori (MOH, 2006; Robson & Harris, 2007). Māori were particularly vulnerable over a period of structural and economic reform within New Zealand and were hardest hit by high unemployment and low incomes, contributing to their poorer health status compared to other New Zealanders.

Determinants of Māori Health

The ethnic inequalities between Māori and non-Māori in health are undeniable (Ajawani et al., 2003; MOH & University of Otago, 2006; Robson & Harris, 2007). The issue of health disparities is not attributed to one or two influencing factors, but is the result of a combination factors;

these factors include the historical experiences of colonisation, the economic and social reforms of the 1980s and 1990s, socio-economic position of Māori in New Zealand today, institutional and interpersonal racism and poor access to health services. Māori experience disparities across all social and economic sectors, including education, employment, income, housing, criminal justice and health (Te Puni Kokiri, 2000). But disparities in health between Māori and non-Māori continue to be consistent, and are considered to be the most significant factor to contribute to the overall state of Māori health today (Ajwani et al., 2003; Ministry of Health & Otago University, 2006; Robson & Harris, 2007).

The contributions of interpersonal and institutional racism significantly influence poor Māori health outcomes and inequalities between Māori and non-Māori in New Zealand. (Harris, et al., 2006). Harris et al. (2006) examined the 2002 to 2003 New Zealand Health Survey data for the effect of self-reported experiences of racial discrimination in health. They found that inequalities in health were most evident between Māori and Europeans. When participants were asked about an experience of an ethnically motivated attack (physical or verbal), or unfair treatment because of ethnicity (by a health professional, in work or when gaining housing), Māori reported the highest prevalence (34%) of ever experiencing any forms of racial discrimination, and were 10 times more likely to experience multiple types of discrimination compared to Europeans and others (4.5% versus 0.5%). Both nationally and internationally there is increasing evidence to suggest that racism is a major determinant of health, and a fundamental driver of ethnic inequalities. (Bhopal, 2006; Harris, et al., 2006; Nairn, et al., 2006; Robson & Harris, 2007).

Bhopal (2006, p.1958) stated that “white populations of European-origin within multiethnic societies are generally richer, more powerful and enjoy better material wealth”, and suggested that health services are also better than those available to non-white ethnic minority groups. Ethnic health inequalities in European/white dominated societies are inevitable as racism is thought to contribute significantly to socio-economic deprivation and subsequently plays a role in causing health inequalities. Blakely and Wilson (2006) support this position and further suggest that personal and household income predict mortality risk, and proposed that each additional dollar of income contributes to a slightly smaller decrease in the mortality risk. The current consensus is that by narrowing income distribution it will inevitably improve overall health.

The gaps between Māori and non-Māori mortality widened over the 1980s and 1990s mainly due to steadily declining non-Māori mortality rates and stagnant Māori mortality rates. (Blakely, et al., 2004). The economic reforms during that time saw the personal and household incomes for Māori decline, and the mortality rates rise. Māori were also more likely to live in the most deprived communities, and because ethnicity and socio-economic deprivation are intertwined it is difficult to disentangle the relative effects of ethnicity and deprivation. Riddell (2005) suggested that socio-economic deprivation is associated with an increased chance of death and hospitalisation from heart failure, but disparities in heart failure rates cannot simply be explained by the differences in deprivation. Durie (2001) also concurred that the difference in health status between Māori and non-Māori cannot be totally explained by socio-economic factors.

Māori experience longer and slower pathways through the healthcare system and hospitalisation rates are disproportionately lower in disease categories where Māori have high death rates (Ministry of Health, 2006; Robson & Harris, 2007). The health system is structured in such a way that people without access to transport or resources have more difficulty accessing both treatment and prevention services. Davis et al. (2006)

stated that the quality of health care received by Māori is different; Māori are less likely to receive appropriate levels of care in screening and treatment for disorders, such as ischaemic heart disease and diabetes, and experience higher levels of adverse events. Jansen & Smith (2006) described other inequities in primary health care, such as fewer investigations and blood tests, and that Māori are less likely to be recommended follow-up appointments and referred to hospital specialists for further care.

Indigenous Health Status

Disparities in health status exist for indigenous people across the world, in countries whose foundations were based on colonisation by Europeans, such as New Zealand, Australia, Canada and the USA. Horton (2006) suggested that indigenous peoples are consistently marginalised from the political, economic and social mainstream, and their ability to strengthen their cultural identities is getting harder. For most indigenous peoples poverty is endemic, political representation is weak, access to education is highly variable, and displacement and human rights violations are common (Horton, 2006). Poor health experienced by indigenous groups compared to others in their population is considered the most difficult problem of all. This is demonstrated through substantial systematic inequalities and consistent disparities experienced by indigenous people when compared to the non-indigenous population (Bramley, Herbert, Jackson & Chassin, 2004). The gap in life expectancy between the indigenous and non-indigenous populations is estimated to be 17 years for Australia, 9 years in New Zealand, 5-7 years in Canada and 4-5 years in the USA (Anderson, et al., 2006; Ring & Brown, 2003)

In the USA, racial and ethnic minorities continue to experience poorer quality of care when compared to the white population. When considering the indigenous population it was found that the quality of care was 41% poorer compared to the white population in 22 essential qualities of care measures (Chin, Walters, Cook & Huang, 2007). White Americans receive a higher quality of health service, and are more likely to receive routine medical procedures than other ethnic groups (Blakely, et al., 2004). Despite the increasing public attention devoted to health disparities and the growing public investment in quality improvement interventions, significant racial and ethnic disparities in care and outcomes still exist for many conditions, including cardiovascular disease, diabetes, depression, and breast cancer (Chin, Walters, Cook, & Huang, 2007).

The indigenous population of Australia represent 2-3% of the total population. When compared with the populations of New Zealand, Canada and the USA, Aboriginal and Torres Strait Islanders experienced the greatest disparity in life expectancy when compared to their non-indigenous population (Bramley, Herbert, Jackson & Chassin, 2004). According to a United Nations index that measures human development, Aboriginal and Torres Strait Islanders now experience the second worst quality of life, with China faring the worst (Armstrong, 2004).

The indigenous peoples of Australia suffer from high disease specific mortality rates. Life expectancy at birth is 56 years for indigenous males and 63 years for indigenous females, compared to 76 for non-indigenous males and 82 for non-indigenous females (Bramley et al., 2004). Babies born to Aboriginal and Torres Strait Islander mothers are twice as likely to die at birth as non-Indigenous babies. Aboriginal and Torres Strait Islanders adults die at three times the rate of the rest of the population, and are 20 times more likely to die from rheumatic heart disease, 8 to 12 times more likely to die of endocrine disorders, 10 times more likely to die from cardiovascular disease, 1.5 times more likely to die of cancer, and twice as likely to commit suicide as non-indigenous Australians. (Armstrong, 2004).

Ring and Brown (2003) have suggested that the four main conditions of circulatory disease, injury, respiratory illness and diabetes account for almost 70% of the preventable deaths for Aboriginal and Torres Strait Islanders and while treatment and prevention of these conditions is possible there exists a lack of commitment by federal and state governments to do so. They also suggested that spending money on Aboriginal and Torres Strait Islander health was a vote loser in the marginal seats. Despite the total per capita health funding for Aboriginal and Torres Strait Islanders exceeding that of non-indigenous people, there was strong evidence to suggest that the money was being used inappropriately.

In Canada, First Nations, Inuit and Metis comprise approximately 4% of the Canadian population and are recognised constitutionally as Aboriginals. The Aboriginal population of Canada are characterised by considerable social and health related disadvantage compared with other Canadians. (Reime, Tu, Lee & Canadian Neonatal Network, 2007). Poverty rates are high, housing conditions are often inadequate, and the situation is exacerbated on reserves or in remote areas. The morbidity and mortality rates are in excess of the Canadian average, with male Aboriginals life expectancy 64 years compared with 73 years for Canadian males, and for female Aboriginals 71 years versus 79 years for other Canadian females. Indigenous Canadians also reported poorer health. It was thought that the health seeking behaviour of the indigenous Canadians may be adversely affected by the loss of traditional cultural values and lifestyles, reflecting a conflict between Aboriginal and western values (Newbold, 1998).

Despite the Treaty of Waitangi and the Tangata Whenua (People of the land) status, it appears that, just like other indigenous groups around the world, Māori experience poor health when compared to their fellow country men.

Māori and hospitalisation

Considering the high rates of Maori morbidity and mortality there is a paucity of literature relating to Māori experiences of hospitalisation. Maori have had over a hundred years of exposure to the western concept of the containment and isolation of the ill within a hospital environment; therefore it is necessary to understand the historical context of Maori and hospitals.

As the immigrant population grew in New Zealand, particularly during the gold rush years of the 1860s, more hospitals were established to meet the needs of mining communities. Most hospitals were not government funded but were established through community efforts and service charges, although in 1846 the colonial government established the first of four state hospitals in Auckland, Wellington, Wanganui and New Plymouth. Māori historically were reluctant to go to these hospitals. Buck (1966) described having difficulty persuading Māori with serious cases of infectious illness to go to hospital for treatment - he believed that limited visiting hours were partly the cause of Māori reluctance to be hospitalised, and this restriction on visiting and a relative staying fuelled suspicions of hospitals and western medicine by Māori (Buck, 1966). So as to avoid hospitalisation, it was also not unusual for Māori to hide those who were sick in the bush when a native health nurse or health inspector was expected (McKillop, 1998). For many Māori, western medical knowledge was not recognised as the answer to their health problems. Traditional forms of treatment continued to be sought for illness, while seeking medical advice from a doctor was avoided, or generally left until an illness was extreme and medical intervention was of little use.

Several other factors contributed to the low admission rates of Māori to hospital at the beginning of the 20th century. These included the poor distribution of hospitals, and their distance from Māori communities; discriminatory admission policies of some hospitals, many hospital boards reluctant to take Māori as they would not, or could not pay their fees; as well as Māori reluctance to use the services available. Māori predominantly lived in the rural areas, access to hospitals was therefore restricted by the distance from Māori communities and Māori commonly believed hospitals to be places for Pākehā. Hospitals had a bad reputation amongst Māori, and they were considered to be a place where you went to die, knowledge of disease processes was low, and many Māori did in fact die when eventually admitted to hospital. Māori opposition to hospitalisation was common and when a few could be persuaded, it was considered a last resort. Language barriers and the fear by Māori of being unable to pay the doctor's fee further complicated relationships between the Pākehā doctor and the Māori patient. Cultural preference meant that a sick person was more likely to see a Tohunga rather than a doctor (Lange, 1999).

It is uncertain if these attitudes about western medicine and hospitals continued to influence Māori admissions to hospital during the early part of the 20th century. What is apparent is that by the 1970s evidence suggests utilisation of hospitals, particularly psychiatric hospitals, began to increase (Durie, 2001). In describing an increase in Māori psychiatric admissions during the 1970s, Durie (2001) identified three specific phases. Phase one was the period prior to the 1970s; during this phase Māori were generally under-represented in psychiatric admissions. The second phase was the period from 1970 to 1974, during this four year period Māori admission rates into psychiatric facilities rose to the same rate as non-Māori. The third phase from 1975 onwards, saw Māori rates of admission rise dramatically and in some cases exceed non-Māori admissions for some age groups. Durie explained that while urbanisation and the associated social and economic stressors might directly be associated with an increase in mental illness, several explanations for the rise in admission rates must be considered.

First, the admission rates could reflect a greater utilisation of psychiatric facilities by Māori than represent an increase in mental disorders. Prior to the 1970s Māori had limited access to hospital facilities, families assumed the burden of care, and often Māori were denied the opportunity of specialist treatment. Second, a change to ethnic identity based on self-identification rather than the blood quantum method occurred around the same period, which meant more people were able to identify as Māori. Also hospital authorities introduced a more systematic approach to recording ethnicity (Durie, 2001). Although these examples provide possible reasons for increases in psychiatric admissions, never-the-less, the trend is relevant in relation to possible changing Māori attitudes towards hospitalisations at that time.

Contemporary literature suggests that major inequities exist within health services, despite Māori experiencing higher rates of admission to hospital than those of non-Māori for nearly every major cause. (Davis et al., 2006; Robson & Harris, 2007). A retrospective cross-sectional assessment by Davis et al. (2006) examining the quality of hospital care received by Māori patients found they accounted for just over 15% of admissions and were on average younger, more likely to be from deprived areas, and more likely to be admitted with co-morbidities. This assessment also found that once in hospital Māori not only experienced a shorter length of stay than non-Māori but 14% of Māori admissions were associated with an adverse event, compared with 11% of non-Māori admissions. These authors concluded that despite a predominately publicly funded hospital system, hospital care received by Māori is marginally poorer than that received by other New Zealanders.

Current Literature

Published research in relation to Māori experiences of hospitalisation has been difficult to find and only small amounts of literature reviewed examined the experiences of Māori as health care consumers going through the health system. A study by Westbrooke, Baxter, and Hogan (2001) examined hospitalisation rates for selected heart disease related diagnoses by age, gender, ethnicity and deprivation, and found that differences by ethnicity were disturbing. Hospitalisation rates for Māori were typically more than double the non-Māori rates, but in contrast potentially life-saving cardiac surgical intervention rates were much lower. Westbrooke et al. questioned how well Māori needs were being met, and how equitable access to cardiac intervention was.

A qualitative research project using a Kaupapa Māori research approach investigated how Māori talk about health; Māori health and Māori experiences of interacting with both mainstream and Māori health care providers. Twenty eight Māori participants were interviewed and 12 themes identified, from which an overview of Māori health was conceptualised. The conclusion suggests that healthcare for Māori should be holistic and provided in and respectful and collaborative way (Cram, Smith, Johnstone, 2003)

Using a grounded theory methodology, Wilson (2004) examined what was important for Māori women in regards to their health and wellbeing and in doing so, described Māori women’s experiences of mainstream health services. Māori women described access to and use of health services was hindered by, among other things, fear and past experiences, whānau dying in hospital, and negative contact with health care professionals. Wilson outlined what Māori women needed when they engaged with health services in order to establish the trust required to access and use those services, and recommended ways that health care providers could improve their relationships with Māori women.

Bolitho and Huntington (2006) carried out qualitative research using thematic analysis. This study explored Māori families' experiences of accessing health care when their children are unwell with a respiratory condition. Four families were interviewed and discussed their experience of accessing health care for their sick children. Three common themes arose; family resources, choice of health service provider, and parents' feelings of vulnerability. The findings suggested that while socio-economic status played a significant role in determining the ease with which families could access health care, barriers existed within the system that made it difficult for Māori. Bolitho and Huntington concluded that mistrust and barriers to usage remain, and changes in the New Zealand health system aimed at improving access and affordability for Māori families have had little effect.

Exploratory research by McKinney (2006) examined Māori experiences of hospital care in Auckland. McKinney presented nursing education providers with some insight into the effectiveness of cultural safety education and its implementation into nursing practice. McKinney determined that despite improvements over the last 10 years to provide culturally appropriate Māori health services within hospitals, the experiences of Māori in hospital remains problematic. Recommendations were made for the involvement of Māori consumers in service development and provision, for better communication between health education and providers to improve cultural competence, and called for the evaluation of current Māori health services to improve access.

The current literature describing Maori experiences in the mainstream health system and hospital environments not only provide some insight into the experiences of Maori but also demonstrate the lack of coordinated research into the phenomenon and provide some rationale for this thesis study.

Māori Health and Nursing

Maori were to also experience the evolvement of rural and native nursing practice in New Zealand. During the epidemics that swept through Maori communities in the late 1800's and early 1900's, nurses were sent into the rural Maori communities where they established makeshift hospitals to treat and educate Maori about managing Pākehā disease.

At the turn of the 20th century Māori were significantly at risk due to the devastating effects of infectious diseases introduced as a result of colonisation. Seeing the state of Māori health and the gradual decimation of their race, members of the Te Aute Association, early Māori leaders such as Dr Maui Pomare, Dr Peter Buck and Apirana Ngata, sought ways in which they could improve Māori health. Realising that the colonial government's health system failed to address their needs, members believed that self determination would be the only way to improve the health of their people. At the 1897 Te Aute Conference, the idea that young Māori women be trained as nurses was promoted as it was hoped that large scale training of Māori nurses would affect changes to Māori health practices and outcomes. The idea of Māori recruiting and addressing their own health needs was met with support from government officials. But it was eventually the concern of the spread of infectious disease from Māori communities to Pākehā settlements that led to real efforts to assist with Māori and their health problems (Lange, 1999; McKegg, 1991).

In 1898 a Māori nursing scholarship was established and was followed by the enrolment of its first two trainees at Napier Hospital. But Pomare's vision of Māori nurses effecting changes to Māori health was never really fully realised as many delays were experienced and Māori nurse trainees were subjected to racial prejudice, which Pomare condemned and perceived as having disastrous limitations on the programme. Feeling frustrated and continuing to see his people succumb to further epidemics, Pomare realised that the supply of Māori nurses was unlikely to show a rapid increase and became resigned to the idea of a Māori health nursing service that employed Pākehā nurses (Lange, 1999). The Native Health Nursing Scheme was eventually established in 1911 and by 1920 there were 20 mainly Pākehā Native Health nurses around the country. Both Māori and nurses worked vigorously within the health service to effect change that would gain them recognition and financial support from the government. But the overriding beliefs and infrastructure of the time had established health services which held both Māori and nurses in a disadvantaged position in terms of status and power (McKillop, 1998).

McKegg (1991) disputes the view that the improvement in Māori health by the 1930's was attributed to the reforms directing nurses towards preventative work in the treatment of tuberculosis. For approximately 20 years before the reforms were implemented individual nurses were working in Māori communities, coping with accidents and illness, and most importantly teaching through compromise the basis of western scientific medicine. McKegg (1991) believed that Māori health nurses prepared the way for the reforms, and through working closely with Māori communities were able to make a profound difference to Māori health outcomes.

The Native Health Nursing scheme continued up until 1930. In 1930 the Director General of health, completed a survey of Taranaki, North Auckland and the East Coast in order to establish the exact number of nurses working in these districts in various roles, whether there could be a better distribution of nurses, whether there were sufficient numbers, and what would be required to develop a general public health nursing service. Eventually restructuring occurred based on geographical area, rather than the ethnicity of the population. Nurses were expected to provide public health nursing to all residents regardless of whether they were Māori or not. The entire notion of a special nurse for Māori was phased out (McKillop, 1998).

Māori Health and Nursing in Contemporary Times

As a result of changes in health policy and government restructuring of the health services during the 1990s, Māori health services were established. Iwi and pan-tribal groups were able to tender for primary health care contracts to provide services to an enrolled population (Ellison-Loschmann & Pearce, 2006). As a consequence of the development of Māori health services, Māori specific nursing was established again, but the difference compared to the past was that Māori were now able to employ Māori nurses to work with Māori, in Māori communities. Many Māori nurses took the opportunity to move out of mainstream health services, choosing to work within their own tribal areas. Māori nurses work in diverse roles in the community, such as practice, mental health, and primary health care nursing, in either Iwi (tribal) or pan-tribal health care services. Working with their 'own' has allowed the Māori nurse to develop nursing practice that takes into consideration their own tribal tikanga (practices) and kawa (customs), with the guidance of their own Kaumātua (Elders) (Close, 2005). Within the mainstream secondary health care sector, some District Health Boards have Māori specific nursing positions, but often these positions occur at senior levels of the organisation (i.e Director of Nursing in Māori Health).

Conclusion

Despite the introduction of Māori primary health care providers, Māori remain high users of secondary health care services. Māori are more likely to be sicker when presenting to secondary health care services, and more likely to be hospitalised, but when they are hospitalised receive a poorer quality of care and are more likely to be discharged earlier than the Pākehā in the bed next to them (Davis et al, 2006; MOH, 2006; Robson & Harris, 2007).

Māori receiving health care either in the community or in a hospital are more likely to receive care from a non-Māori health professional, and increasingly, a person from another country. Despite the evidence linking Māori health status to socio-economic deprivation the negative stereotypes, victim blaming, and deficit explanations continue to be articulated by nurses and doctors, particularly when indigenous people do not respond positively to prescribed health interventions. Many health services continue to deliver culturally inappropriate services and tend to neglect the worldview of indigenous people, offering a service based on the dominant biomedical model (Durie, 2001; McCreanor & Marim, 2002; Reid, Robson & Jones, 2000).

So why do Māori experience a shorter length of hospital stay when compared to non-Māori? What is the experience of Māori in hospital? There is a paucity of research that explores the experiences of Māori hospitalisation; therefore, it is the intention to examine Māori experiences of hospitalisation and attempt to understand how their experiences could relate to the length of their hospital stay.

CHAPTER 3

RESEARCH DESIGN AND METHOD

Introduction

Increasing evidence suggests that Māori are not accessing health services at the same rates as non-Māori, and when health services are accessed their health conditions are more acute and complex (Kerr, Gamble, Doughty, Simmons, & Baker, 2006; MOH, 2006; Robson & Harris, 2007). Notwithstanding the more acute and complex health conditions, Māori on average are in hospital for a shorter stay compared with non-Māori, and the hospital care received by Māori is marginally poorer than that received by non–Māori (Davis et al., 2006).

Although there exists a wide variety of literature exploring the probable barriers to health care for Māori, virtually no information about the individual health experiences of Māori is evident. A literature review identified gaps in health research relating to this topic. There is also very little recent literature on Māori beliefs and attitudes about health and illness, although much theoretical discussion regarding the determinants of Māori health and associated disparities (Caccioppoli & Cullen, 2005; Collings & Ellis, 1997; Durie, 2001; Dyall, 1997; Howden-Chapman & Cram, 1998; Ministry of Health, 2006; National Health Committee, 1998; Reid et al, 2000; Robson, 2004).

This research seeks to ask Māori about their experiences of hospitalisation and consider the possible influence these experiences may have on their length of stay (LOS). Understanding what occurs when a Māori patient is admitted to hospital is a key aim of this research project. When planning the best methodological approach to examine and understand this phenomenon, a case study research methodology with a Māori centred research approach was considered the most appropriate.

Māori people are considered to be one of the most researched indigenous people in the world (Smith, 1999) and for that reason; this chapter will begin by discussing Māori experiences and perception of research in to their lives. The philosophical foundations of Māori centred research are explained through the description of the methodological principles of Kaupapa Māori research. The following section will discuss Māori centred research principles and describe how they relate to this research project. The methodological principles of case study research, the research method including data collection and data analysis will be presented, and then finally the ethical considerations and limitations relating to the research will be discussed.

Māori and Research

To understand the philosophical foundations of Māori centred research, it is necessary to understand from where it evolved. Within the paradigms that have operated in New Zealand, Māori views and experiences have not always been easily catered for. In an attempt to rationalise Māori knowledge in western terms, Māori knowledge was categorised as ‘other’ within the research, science and technology sector. Therefore the development of kaupapa Māori research theory was an attempt to move Māori research out of the scientific western positivist and constructivist paradigms, placing it aptly in an epistemology that is based on Māori ways of knowing and viewing the world (Cunningham, 1998).

Cunningham (1998) suggested that a traditional and conservative Māori worldview is central to Māori knowledge. He described it as a view that is based on wholism, an Iwi based social system, and oral tradition. Kaupapa Māori research has been defined as a methodology that has Māori in control and is by Māori, for Māori, informed by a Māori philosophy (Bishop, 1997b; Smith, 1999). Furthermore, it is proposed that Kaupapa Māori places Māori experience and analysis at the centre of the theoretical base, accepting Māori processes as reality and using Māori analysis to produce Māori knowledge that meets the expectations and standards set by Māori (Cunningham, 1998). Marsden (2003) claimed:

> Cultures pattern perceptions of reality into conceptualisations of what they perceive reality to be; of what is to be regarded as actual, probable, possible or impossible. These conceptualisations form what is termed the 'worldview' of a culture. The worldview is the central systemisation of conceptions of reality to which members of its culture assent and from which stems their value system. The worldview lies at the heart of the culture, touching, interacting with and strongly influencing every aspect of the culture (p.177).

Methodological Principles of Kaupapa Māori Research

Within the literature it appears that there is no 'one' set of methodological principles for Kaupapa Māori research but instead there exists a myriad of viewpoints and theories. The most essential principles are 'being Māori', identifying as Māori and as a Māori researcher (Cunningham, 1998; Mead, 1996), and that the research is connected to Māori philosophy, principles and epistemology (Bevan-Brown, 1998; Mead, 1996). When identifying the principles, common themes exist, and include suggestions that the research must be:

1. Empowering and beneficial to the participants (Bevan-Brown, 1998; Bishop, 1997b; Mead, 1996);
2. Focussed on areas of importance and concern to Māori, and that the research must be culturally acceptable and assessed by culturally appropriate methods (Bevan-Brown, 1998; Bishop, 1997b; Cunningham, 1998); and
3. Formative with its own methodologies that employ a range of contemporary and traditional methods (Bevan-Brown, 1998; Royal, 1998; G. H. Smith, 1990, 1992).

Culturally acceptable methodological principles such as whakapapa, te reo, tikanga Māori, rangatiratanga and whānau (Bevan-Brown, 1998; Mead, 1996; G. H. Smith, 1990) are considered the working principles of Kaupapa Māori and tend to encompass many of the methodological definitions of Kaupapa Māori research.

Despite differing views in relation to the methodological principles of Kaupapa Māori research, key similarities exist with regard to the research process. Access to research participants in kaupapa Māori research is based on the Māori paradigms of whakapapa and whanaungatanga. Often culturally appropriate forms of engagement are employed such as mana (the research should have a positive contribution to Māori aims), māramatanga (the enlightenment attained through the enhancement of mana), mahitahi (working together), and whakawhiti kōrero (conversation) (Bevan-Brown, 1998; Bishop, 1997a; Durie, 1998; Keefe, Cram, Ormsby, & Ormsby, 1998; L. T. Smith, 1999). Researchers will often be members of the same whakapapa, whānau, hapu, iwi and the wider community, and therefore may be sanctioned to access a participant group (Bishop, 1997a; Keefe et al., 1998; L. T. Smith, 1999).

Kaupapa Māori research utilises ‘whakapapa networks’ in the research sampling process. This has a ‘snowballing’ effect where a key informant will identify within a whānau, hapu or Iwi who would be the most appropriate to participate in the research. This process acknowledges relationship-driven consultation and is considered by some researchers as productive and proactive (Keefe et al., 1998). Data collection is a participatory process, with whānau, hapu or iwi included, as the participant desires. Information may be gathered from the collective, even if the research is related to the individual. Kaupapa Māori research can be a qualitative narrative research and measured through the developing themes that occur within the narratives. Analysis of data is carried out using Māori epistemologies. Cunningham (1998) explains that a Māori analysis does not discount the advances in technology made this century, but in the process of achieving the ultimate goal of Māori development, will utilise Māori philosophical contexts.

Ethics within kaupapa Māori research has been defined from a Māori perspective as tikanga, reflecting Māori values (Powick, 2002). Mead (1996) and Durie (1998) have both developed concepts relating to the ethical issues of kaupapa Māori research. These concepts take into account ethical situations such as, *‘mana tangata’*, (Durie, 1998) which, like Mead’s (1996) ‘*Kia Tūpato’* considers mutuality, safety and respect of participants and researcher. ‘*Mana Whakahaere’* (Durie, 1998) is concerned with collaboration and power, and *‘Aroha ki te Tangata’* (Mead, 1996) considers a formal approach to interviews, which, in contrast to western approaches, the hierarchy position of the researcher is removed. Other ethical perspectives include *‘mana motuhake’* (Durie, 1998), which considers the benefits of research to Māori. *‘Kaua e takahia te mana o te tangata’* highlights the importance of conducting respectful research while *‘Kaua e māhaki*’ reminds researchers to be humble during the research process (Mead, 1996)

Historically, mātauranga Māori (Māori ways of knowing) was not considered a legitimate way of knowing within the dominant New Zealand western culture (Wilson, 2004). Despite indigenous knowledge possessing its own systems of rigour that have survived time, research methodology based solely on Māori philosophical beliefs and social practices do not carry the same validity or emphasis in western scientific eyes (Cunningham, 1998; Smith, 1999; Wilson, 2004). Kaupapa Māori research embraces traditional beliefs and ethics while addressing Māori concerns about research and incorporating strategies that drive for Tino Rangatiratanga (self determination) (Henry & Pene, 2001).

Defining Māori Centred Research

Although not clearly stated in the literature, the theoretical perspective of a Māori centred approach to research would naturally be mātauranga Māori, or Māori ways of knowing. However, Cunningham (1998) identified, as with Kaupapa Māori research, Māori centred research employing a Māori methodology and analysis, the difference being that often the methods and analysis can be employed alongside mainstream or western methodologies and utilise mainstream or western analyses (Cunningham, 1998; Powick, 2002). The outcome of a Māori centred approach to research is the generation of Māori knowledge (Wilson, 2004). Wilson (2004) explains further that a Māori centred approach is informed by a set of assumptions that include concepts similar to kaupapa Māori research, such as the benefits of research to participants, the use of a holistic approach that considers the ‘multiple and complex interactions’ of Māori, and finally, that Māori must remain in control of the research process. Furthermore, both Cunningham (1998) and Wilson (2004) identified a limiting aspect of Māori centred research is that the researcher needs to be accountable to both Māori and mainstream, which could result in conflict.

As a way of internationalising a Māori centred approach, Durie (2005) redefined Māori centred research as a methodological research practice for all indigenous cultures. The theoretical underpinnings are taken from a much broader context, rather than a purely Māori paradigm, in that it acknowledges the historical and contemporary similarities of the indigenous research experience and indigenous rights, and recognises the debate regarding the validity of indigenous knowledge within scientific research. Durie (2005,) suggested that despite the “methodological gulf” that existed between science and indigenous knowledge, there was room for “each system to accommodate the other” (p.141). The aim of indigenous centred research is to “utilise the energy from two systems of understanding in order to create new knowledge that can be used for further development” (Durie, 2005, p.141).

Methodological Principles of Māori Centred Research

In carrying out grounded theory research with a Māori centred approach, Wilson (2004) developed a model of a Māori centred approach to research within a mainstream environment. The model, in the form of a kākano (seed), places Māori central, or at the seeds’ rito (centre), the first outer layer of the seed, includes Durie’s (1997) principles of mana Māori (control), whakapiki tangata (enablement) and whakatūia (integration), which Wilson (2004,) described as “cornerstones of a Māori centred approach” (p.85). The next layer of the seed considers Māori research requirements, concepts similar to kaupapa Māori research, such as kanohi kitea (the known face), rangatiratanga (determination), whakapapa (genealogy) and whānau (family), Te Tiriti o Waitangi, benefits and consultation. The final and outer layer of the seed, keeping Māori central, has mainstream research requirements located on the periphery. Wilson’s (2004) model helps to better define Māori centred research, and demonstrates how the researcher must have Māori interests at the core of all interventions.

Using a framework developed to demonstrate the relationship between indigeneity, research, science and technology, Durie's (2005) work brings together five key concepts - *outcomes, principles, research paradigms, capability, and effective policies*. The *outcomes* dimension is considered to be the most important component of the framework as it highlights how new knowledge should contribute to Māori social, economic, cultural and environmental advancement, through using measurement tools that are consistent with Māori worldviews (Durie, 2004, 2005). The principles of indigenous centred research considers mutual respect, shared benefits, human dignity, discovery, innovation and exploration. *Research paradigms* acknowledge the dual methodologies of indigenous and scientific approaches to research, and recognise the philosophical differences while working towards the positive outcomes of the research. *Capability* comprises advancement and development through the involvement of Māori in science and research. Finally, *effective policies* challenge the research, science and technology sector to not only respond to Māori research needs, but to also consider the broader issues of Māori advancement and development (Durie, 2005)

Māori centred research as with Kaupapa Māori research employs a Māori methodology and analysis, the difference being that often the methods and analysis will be employed alongside western/mainstream methods and utilise mainstream analysis (Cunningham, 1998). This approach has Māori remain central to the research but allows both Māori and western belief systems their own integrity, therefore utilising the energy of two systems of knowledge in order to generate new knowledge for the benefit of all (Durie, 2005).

When taking into consideration the core principles of Māori centred research (Cunningham, 1998; Durie, 2005; Wilson, 2004) and applying them to this research, Wilson’s kākano model was found to be the most appropriate approach to guide this research process. As an intervention to ensure that Māori remained in control of the research, a whānau support and advisory group was established to guide and support me through the research project. Members of the support team included, another Māori nurse, a Māori researcher, Iwi health promoters and a Kaumātua. Support team members regularly meet with the researcher to discuss progress of the project and discuss any issues that may have arisen through the research process. A Māori thesis supervisor was also available to discuss theoretical and methodological aspects of the research.

The first principle of Māori centred research utilised when engaging with participants was kanohi kitea, the researcher consulted with Iwi, whānau networks, as well as friends and colleagues to seek their support and to recruit participants. Māori were placed at the rito (centre) of all research actions, and from the conception of the research topic it was essential to consider the benefits this research would have for Māori. It was explained to participants that benefits as a result of this research may not be immediately apparent, but potential benefits may be seen as a consequence of further ongoing research and the generation of new knowledge. Control of the research process was retained by the participants, in that they were able to choose where and when they would be interviewed, if they wanted family present, how the information would be gathered, and what information would be used. All participants were provided with a copy of the interview and were able to remove or amend information if required. Participants had the opportunity to withdraw from the research at anytime.

Case Study Research Methodology

Case study research is qualitative research, which is suited to situations when the focus is on contemporary phenomena within a real life context (Yin, 2003). Case study research is used to investigate situations where little is known about what is there or what is going on, when it is necessary to “get under the skin” of a group, or to view a case from the inside out. But significantly, in relation to this project, case study enabled research into the ‘processes’ leading to the issue under examination rather than into the significance of the issue itself (Gillham, 2000). Case studies are richly descriptive because they are grounded in deep and varied sources of information (Hancock & Algozzine, 2006).

Research design

A single case study focuses on a one case only, whereas multiple case studies can include two or more cases within the same study. Single or multiple case study designs can be exploratory, descriptive or explanatory (Yin, 2003). Exploratory case study design seeks to define the research questions of a subsequent study or to determine the feasibility of research procedures. A descriptive case study design provides a complete description of the phenomenon within its context. An explanatory case study design aims to explain how things happen, by examining cause and effect relationships (Hancock & Algozzine, 2006). Stake (1995) also divided case study designs into different categories of intrinsic, instrumental and collective. ‘Intrinsic case studies’ focus on improving the general understanding of a particular case, whereas an ‘instrumental case study’ provides insight into other phenomenon; to understand something else, while a ‘collective case study’, as with Yin’s ‘multiple case study’, examines a number of cases to gain a better understanding of phenomenon.

Yin (2003) explained that a single-case study is equivalent to a single experiment because many of the same conditions that justify a single experiment also justify a single case-study. In relation to this research a *revelatory* single-case design was chosen because it allows the investigator the opportunity to observe and analyse a phenomenon that was previously inaccessible to scientific investigation. Identifying the unit of analysis is significant at this stage as this will ensure the case is in fact relevant to the issues and questions of interest. Yin (2003) suggests adding subunits of analysis so that a more embedded (complex) design is developed which will enhance insight into the phenomenon. The diagram below illustrates a single-case embedded design.

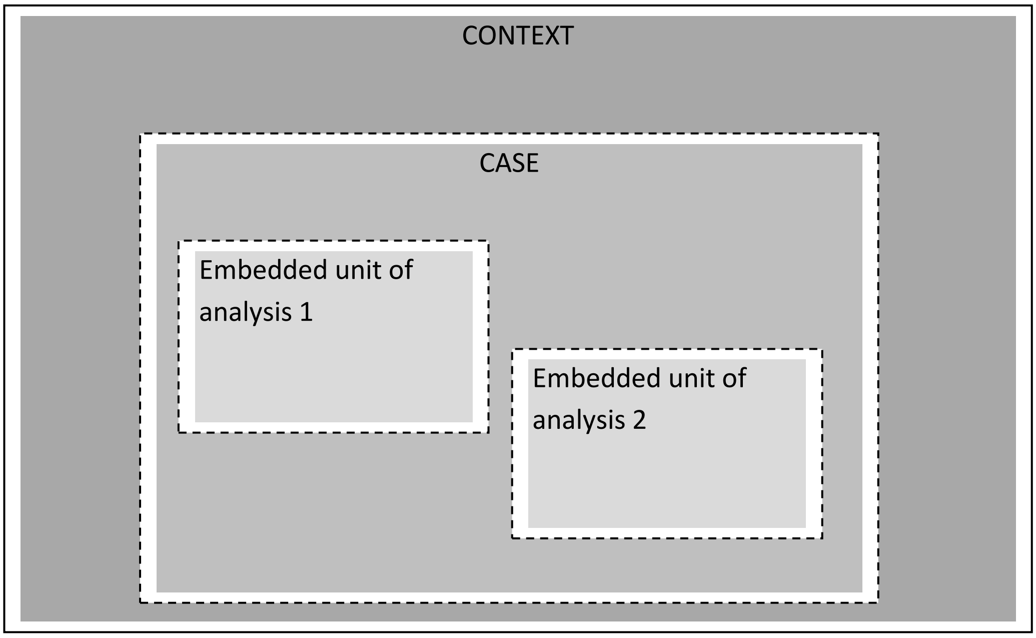

Figure 3.1. Embedded single-case study design

Note. Source: Yin, R. (2003). *Case Study Research Design and Methods* (Third edition ed. Vol. 5). USA: Sage.

An intrinsic single case study (embedded) design (Stake, 1995; Yin, 2003) will be used. The intrinsic aspect of the design will focus on understanding Māori experiences of hospitalisation, the focus being to learn more about Māori and less about examining or creating general theories or generalising research findings to broader populations. The intrinsic design will allow for the identification of everyday actions and interactions about complex social structures in order to understand the meaning of the experiences of the participants (Hancock & Algozzine, 2006). Multiple sources of evidence will be gathered that will include quantitative statistics, interviews of participants, and international literature regarding indigenous experiences. The diagram below illustrates the study design.

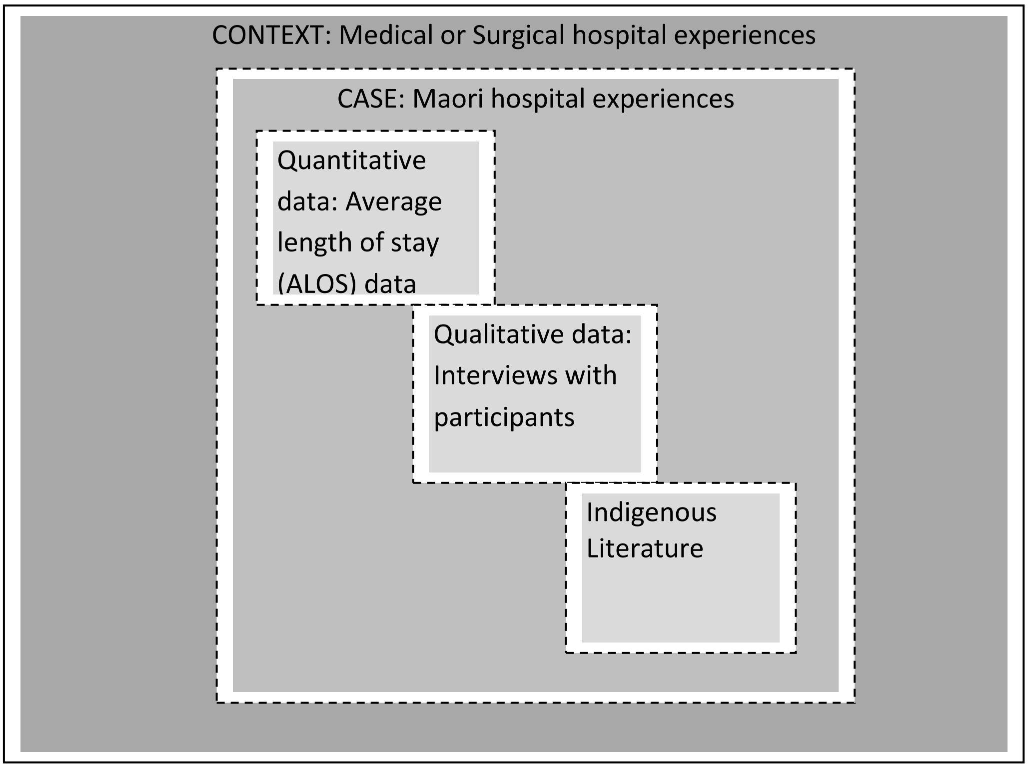

Figure 3.2. Māori experiences of hospitalisation as an intrinsic single-case study (embedded) design

Note: Adapted from Yin, R. (2003). *Case Study Research Design and Methods* (Third edition ed. Vol. 5). USA: Sage

Method

Participants

Eleven participants, all identifying as Māori, of various iwi affiliations, residing in a range of regions were interviewed. Participants were from a mixture of rural and urban locations. All participants had either been admitted, or cared for family member who had been admitted to a public hospital anywhere in New Zealand in a medical or a surgical ward within the last 15 years. Participants were aged between 20 to 75 years.

Participants were recruited using a snowballing technique; requests were made for participants through Māori networks. The researcher attended Iwi hui (tribal meetings), outlining the research aim and potential benefits and invitations were made for potential participants to share their experiences of hospitalisation. Following thorough consultation with potential participants, the boundaries of the research and control of the information collected were established. The proposed benefits and innovations that may come about from this research project were also explained to the potential participants. Participants were given the opportunity to withdraw at anytime as an acknowledgement of the mana of participants, and the influence they have in controlling the outcome of the research.

Data Collection

Gillham (2000) suggested that document and record analysis are essential in developing a ‘true picture’ of phenomena as it enables the researcher to determine the approach to the subject from different standpoints (triangulation), a key aspect of case study methodology. The most important advantage of using multiple sources of evidence is the converging lines of inquiry (triangulation), which suggests that any findings or conclusions are likely to be more convincing and accurate if it is based on several different sources of information (Yin, 2003). The diagram below is an illustration of triangulation adapted to demonstrate the convergence of evidence gathered for this study.

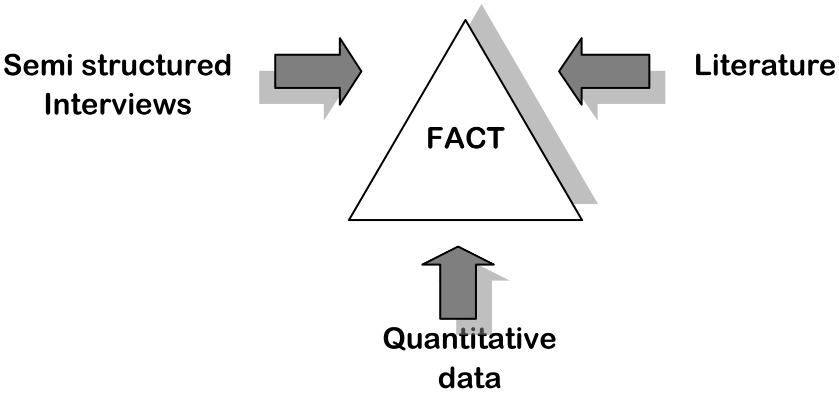

Figure 3.3. Convergence of evidence (embedded single-case study)

Note: Source: Yin, R. (2003). Case Study Research Design and Methods (Third edition ed. Vol. 5). USA: Sage

(a) Semi-structured Interviews

Interviews are essential sources of case study evidence because most case studies are about human affairs, and are reported and interpreted through the eyes of the participant (Yin, 2003). All interviews were held either at the participants’ home or a prearranged venue, the interviews were audio taped, and then later transcribed. The participants were given a copy of the interview and the opportunity to give feedback or make corrections. Following transcription, the interviews were analysed and categorised by tabulating the frequency of different events and then developing a matrix of categories and placing the evidence within each category (Yin, 2003). All transcripts and audio recording were kept in a locked cabinet until returned to the participants.

Research interviews are generally considered part of a survey method, but whether the interviews are oral or written, they are crucial in case study research. Gillham (2000) suggested that it was important point not to be rigid, and if the evidence was relevant and of value, then it is used. Face-to-face semi-structured interviews with 11 individuals were carried out using a mixture of open and closed questions allowing for flexibility while ensuring that key issues were covered during the research interview (Appendix 1).

(b) Quantitative data

A retrospective interrupted time series design was used in a larger study (Wilson et al., 2008) to identify the differential effects of nursing on Māori patient outcomes in the secondary medical and surgical setting, from 1989-2004. Hospital administrative data was used, examining nursing resources, inpatient mortality, length of stay and 11 outcomes potentially sensitive to nursing. Several questions guided the study; the question most relevant to this study asks: Does the change in length of stay over time follow a pattern for Māori and non-Māori? The information was accessed from the NZHIS for all admissions to public hospitals for the years 1989 to 2004. This standard data is collected from the hospitals electronically by NZHIS, who manage access to the data. The data gathered included the records of all medical and surgical discharges for Māori (identified by a Māori ethnicity being recorded either solely or as one of three ethnicities) and non-Māori from the New Zealand public hospitals. Medical and surgical admissions were screened to include those over the age of 17 years and who had a length of stay greater than 1 day and less than 90 days. Excluded records were those under the age of 17 years and those records with major diagnostic categories in obstetrics, paediatrics and mental health. Of interest to the present study was the length of stay data.

(c) Literature

Yin (2003) explained that in case studies the most important use of documents is to corroborate and augment evidence from other sources. An extensive search of the literature was undertaken using the Massey University library catalogue and databases. CINAHL, Web of Science, Ovid and Medline were the predominant databases used, as well as Google Scholar. Key words used included Māori, indigenous, aboriginal, native, health, illness, and hospital, and hospitalisation, average length of stay, ethnicity, inequalities, disparity and nursing. Analysis occurred through examining the similarities of the Māori experience of hospitalisation with other indigenous group's experiences of hospitalisation. Literature from the Aboriginal Australians, the First Nations, Inuit and Metis of Canada and the Native Americans of the United States of America were included in the study. The relevance of this process was to assess and select evidence that would inform the research.

Data Analysis

Analysis of qualitative data

Hancock and Algozzine (2006) explained that when identifying themes they 'must reflect the purpose of the research and respond to the questions under investigation'. The themes 'must evolve from the saturation of the collected information' and the researcher should seek to develop themes that 'represent separate and distinct categories of findings'. Each theme should be as 'specific and explanatory as is allowed by the data' and finally themes should be of comparable complexity (p.61).

Qualitative data analysis consisted of examining, categorising, tabulating and constantly recombining the evidence to address the initial propositions of the study (Stake, 1995). Each case was initially analysed individually, then an analysis was made across the cases. Analysis involved identifying the frequency of themes or events in the narratives. Reoccurring themes were then listed by relativity to the research topic and frequency. Up to 10 sub themes were identified. The themes were then categorised in to 2 overarching themes. Finally the information was collated for this thesis report to give a complete picture of the case and its context, including supportive data from the narratives outlining the findings from the research.

Quantitative analysis

Information from the New Zealand Health Information Service was used to identify the differential effects of nursing on Māori patient outcomes in the secondary medical-surgical setting, from 1989 to 2004. Time series data shows how variables change over time (*trend*), the uniformity of that change (*variability*), and the rate of the variable within which change is occurring (*level*). Therefore, explanations could address any or all of these types of patterns in the data. There was a tendency to place more emphasis on trends, but variability and level phenomena are considered just as important. *Trends* are indexed with regression slopes, which are then calculated in a way that reflects the expected or observed shape of the trend. The resulting statistic then provides an index of how well the chosen summary slope captures the shape of the trend. *Variability* is summarized in a number of ways, such as the standard deviation or variance of the time series. Finally, the *level* can be indexed with means and their differences. (Spicer, personal communication, 9 September 2007). Māori and non-Māori hospital length of stay data was plotted onto a graph that compared trends.

Analysis of Literature

International literature relating to indigenous experiences of hospitalisation and information related to the average length of stay was reviewed and collated. Analysis occurred by looking for common themes and relating them to qualitative data gathered and Māori related literature. The findings were then discussed and similarities identified.

Cross case analysis

Cross-case analysis involves categorising the similarities and differences in the outcomes of the individual cases (Gillham, 2000; Stake, 1995; Yin, 2003). Stake (1995) explains that it is not uncommon that data investigating the same issue yield opposing results. However, the triangulation of data ensures the research is rigorous, and this occurs through the process of the researcher questioning the adequacy of the method used to gather the data. The ultimate aim of triangulation is to identify additional interpretations from the data more than the confirmation of a single meaning. Through the process of analysis key interpretations are developed and eventually conclusions are drawn (Stake, 1995).

Ethical Issues

Ethical consent for this research was obtained from the Massey University Human Ethics Committee: Northern (08/031) (Appendix 2). Actual and potential ethical issues associated with this research were discussed with the thesis supervisor and support team so that strategies could be developed to minimise or eliminate ethical issues impacting on participants. A consent form (Appendix 3) was provided with an information sheet (Appendix 4) advising participants of the research aim, what they were expected to do, and their rights should they choose to participate. A priority was the protection of the participants' identity; participants were informed that all identifying information would be removed from information used within the thesis. Participants had the opportunity to review their interviews and make changes as necessary.

The risk of physical or psychological harm to participants as a result of being involved in this research were minimal, and risks were further minimised through the application of the principles of Māori centred research, such as ‘kanohi kitea’, consultation, and support from iwi and whānau. Data was stored in a locked filing cabinet accessible only by the researcher. All copies of transcripts and audio-recordings will be retained by Massey University following the research project, and destroyed in 10 years after the data was collected.

Limitations

Limitation of Māori Centred Research

As previously discussed, a limiting aspect of Māori centred research is the dual accountability to both the university and Māori. (Cunningham, 1998; Powick, 2002). Durie (2005) explained: "The challenge has been to allow Māori and western belief systems their own integrity, while developing approaches that can incorporate aspects of both and lead to innovation, greater relevance and additional opportunities" (p.145). Māori researchers can interview their own whānau, hapu and Iwi, therefore maintaining the integrity of the Iwi is hugely important. This could ultimately cause conflicts to arise within the research team due to the different methodological approaches, such as the researcher being detached and objective while collecting data. Non-Māori researchers may feel information gathered maybe of significance from a scientific perspective, but as a consequence could expose feelings of whakama or shame for the participants if the information were to become public knowledge. In this situation a Māori researcher could feel a personal and cultural responsibility to the participants, but would feel a professional and financial responsibility to the research unit. In this study the research aims were clearly outlined and a research ethic was put into practice ensuring that all participants were informed and empowered by the process.

Limitations of Case Study Research

Critics suggest that case studies are a poor basis for generalisation (Stake, 1995; Yin, 2003). Stake (1995) suggested that generalisation does occur, in relation to a particular case or a similar case rather than generalisation to a population of cases, as readers recognise the essential similarities to cases of interest to them, establishing the basis for naturalistic generalisation. He also suggested that the process of adding to existing experiences and humanistic understanding is the best use of case study research. The ability to generalise the findings of this study will be useful for further research into Māori experiences within the New Zealand health system. It is hoped that the findings from this research will add to existing Māori health theory and knowledge.

Conclusion

Kaupapa Māori research methodology forms the foundations of Māori centred research - foundations based on Māori ways of seeing and viewing the world. By placing Māori at the rito (centre) of all research interventions and actions the participants remain in control of the research process. A Māori centred approach to research also provided the researchers with the opportunity to discover beyond a single dominant paradigm, it allowed the western scientific methodology to work alongside a Māori paradigm so that a better understanding of the phenomena could be achieved.

An intrinsic single-case study (embedded) design was used to identify contemporary phenomena within a real life context. ‘Intrinsic case studies’ focus on improving the general understanding of a particular case, in this study it focussed on understanding Māori experiences of hospitalisation. A single-case design was chosen because it allows the investigator the opportunity to observe and analyse a phenomenon that was previously inaccessible to scientific investigation. An embedded design allows for the use of multiple sources of evidence. Yin (2003) suggested adding subunits of analysis so that a more embedded (complex) design is developed which will enhance insight into the phenomenon. Through the use of triangulation cross case analysis occurs and eventually key interpretations of the findings are developed. Chapter 4 will describe the findings from the participant’s interviews, these findings will be analysed, and further discussed in Chapter 5 along with analysis of the findings and from the quantitative data and the indigenous literature search.

Chapter 4

FINDINGS

Introduction

This chapter will discuss the findings, firstly by examining the individual data from each case study, and then a cross-case analysis will be carried out, in order to understand the similarities and differences in findings of the individual case studies. The first section of the chapter will discuss the findings from the qualitative data through using examples from the narratives; the next part of the chapter will examine the findings from the quantitative data, describing the data source, data collection and analysis. The objective is to visualise how the variables change over time, so therefore the information will be illustrated through a graph. A discussion will ensue which will lead on to the following chapter, which will further analyse all the data.

Semi-structured Interviews

Qualitative data analysis consists of examining, categorising, tabulating and constantly recombing the evidence to address the initial propositions of the study. Each case was initially analysed individually, then an analysis was made across the cases. Analysis involved identifying the frequency of themes or events in the narratives. Reoccurring themes were then listed by relativity to the research topic and frequency. Up to 10 sub themes were identified. The themes were then categorised in to two overarching themes: Theme 1: A foreign environment, and Theme 2: Whānau caring for whānau. This chapter will begin by describing participant demographics and other relevant data related to the research topic.

Participant Demographics

All 11 participants were Māori, aged between 20 to 75 years, with a history of hospitalisation within the last 15 years to either a surgical or medical ward. The Iwi (tribal) affiliations of participants were varied, although they were predominantly from Iwi groups within the North Island of New Zealand. Six of the participants lived rurally, two lived semi-urban, and three were from urban areas. Of the 11 participants, nine were female and two were male. The median age for the participant group was 46 years. Seven participants identified themselves as having a 'secure cultural identity' using Durie's (2001, p55) *Cultural Identity Framework*, where as four participants described their cultural identity as being between a 'positive cultural identity' and a 'secure cultural identity'.

Six participants chose to speak about their own personal experiences of hospitalisation, while five participants chose to speak about their observations and experiences as the primary carer of a relative hospitalised. Of the 11 participants, two were readmitted following discharge; another participant's relative died while in hospital, and three experienced secondary problems while an inpatient. The types of treatment interventions sought in hospital included, orthopaedic, gastroenterology, neurology, cardiology, urology and gynaecology. The length of admission ranged from 2 to 84 days. Hospitals referred to were mainly larger urban hospitals within the main centres. While some of the participants felt that their hospital experience was positive and incident free, the majority of participants encountered negative experiences as inpatients within the New Zealand public hospital system.

Theme 1: A Foreign Environment

'A Foreign Environment' describes the participants' perspectives of hospital, and comprises of three sub-themes:

- **The hospital environment:** Describes how participants view the hospital environment.
- **Understanding the system:** Discusses Māori frustration and confusion at trying to understand hospital systems and processes.
- **Discharge bargaining:** Provides some insight into discharge strategies that may influence length of stay.

Each sub-theme is discussed and supported by dialogue taken from participant interviews.

Most of the participants agreed that health services informed by a western scientific biomedical approach caused significant discomfort for Māori and their whānau and was considered almost the equivalent to sending them to a foreign country. The "foreign environment" exacerbates feelings of anxiety and alienation, as the hospital is seen as a place for Pākehā, with processes and philosophies that clash with Māori ways of knowing and seeing the world.

The Hospital Environment

Nearly all the participants considered the hospital environment the most likely contributor to why Māori experience a shorter length of hospital stay. Many described hospitals as a "foreign environment" that creates feelings of discomfort, anxiety and stress and likely to exacerbate the urge to want leave hospital as soon as possible:

> *It's a foreign place. I mean, I spent all my life there (in a European system) but you're not comfortable in there (hospital)*. (05:1:12)

As a result of the discomfort experienced, Māori may be leaving before they are meant to because of the stress that comes with being in such a foreign environment:

> *I think that it's an unfamiliar environment. I think it feels really, really strange and foreign. They may as well be in a foreign country because it doesn't feel - You feel like a fish out of water, completely alienated and you feel that it is a strange, strange place and you just can't wait to get the hell out of there and you are only there out of necessity and as soon as you can, even before you're meant to, you get out. Because it is so foreign and so strange and so unfamiliar. (02:1:20)*

There is a sense of alienation. Participants felt that the hospital environment catered more for the Pākehā culture, and as a consequence Māori patients struggled to feel comfortable within the hospital environment:

> *I think there is probably a perception of hospitals being a Pākehā environment and people are uncomfortable with that. They would rather be surrounded by people and things they know. I think if you probably did a poll, Māori people would probably rate a hospital as being a more uncomfortable place than maybe Pākehā would. (03:1:13)*

Feeling uncomfortable within the health environment was considered a significant contributor to Māori anxiety around hospitalisation:

> *I think it’s just an uncomfortable place for Māori, they don’t feel comfortable. They are out of their comfort zone and they just want to go home. And the people around them, they don’t understand. Especially with the old people, they don’t – how our old people are? Our make-up is different. (01:3:8)*

> *I know myself I cannot go somewhere where I don’t feel comfortable, you know. And they feel that too. And who wants to stay in a place where you’re made to feel, well, lower class. Yeah, not comfortable. And how can you get better that way? May as well go home. (11:3:9)*

Many Māori do not have the same beliefs in the health system, they don’t see the system as the only way to meet their health needs, suggesting that perhaps Pākehā put more trust and belief in hospitals and western ways of treatment. This infers that hospitals, while meeting the needs of one culture, alienate other cultures. For example:

> *I think maybe just a distrust of the medicine and the procedures. Like, Māori have their own beliefs about how you get well and stuff – hospitals don’t really incorporate Māori healing and medicine into it. I mean, everything is done in a Pākehā kind of western way and while people recognise that that works, they also know that there is other ways so that being there is not the be-all and end-all of it. I mean, personally, I just have a distrust of them, it’s just rituals and stuff – it’s their belief system. I don’t, like the pills for example, I just think, they believe – but it’s not as real as they seem to think it is – like taking pills and everything being sterile. It’s all kind of a ritual Pākehā tikanga, it’s not necessarily real. But they have a real belief that that’s their way and that’s real, like that’s a route that it’s the absolute way to wellness. (03:3:13)*

Some Māori felt their comfort and cultural needs have to be compromised in the hospital environment in exchange for receiving health care and treatment needed. This is compounded by hospital staff lack of understanding around cultural or alternative ways of treatment and care, or their inability to accommodate cultural differences in treatment and care which in turn contributes considerably to a person's decision to remain in hospital:

> *Because they're (Māori) not comfortable there, they want to be out of there quick. And the problem is they are not looking at the medical requirement, they are looking at getting out of there. That's the priority for Māori. Get out of there, get out of this environment and they're not looking at their health, looking at it from the health perspective. I know when I'm there, I have to keep bringing that to the fore: why am I here? Not for cultural reasons, I am here for health reasons and you have got to keep reminding yourself.* (05:1:12)

> *There's no hope. So we go in there, get what we have to get, and come out as soon as we can, to get out of it because that's the worst part, is the cultural insensitivity for me. And I just can't bear the thought of my kids being under that. (04:1:11)*

An unwillingness to compromise their physical and cultural comforts means Māori put up with hospitalisation for as long as necessary, but when the first opportunity arises, they will leave:

> *I think I came to realise that when you're sick, well I had no choice but to stay there. If I had a choice I wouldn't have stayed there.* (06:1:11)

> *I don't know if we feel comfortable. There's a sense about being comfortable while you are there and I think, I'm looking back again now, that my husband wasn't comfortable there………. Yes. He was one of those that couldn't get out of there quick enough.* (07:1:16)

> *I think Māori would prefer to get out of there as soon as possible* (09:1:10)

The physical and spiritual environment is considered a significant contributor to Māori anxiety about hospitalisation, which includes the fear of death in hospital. The hospital atmosphere was perceived to weigh Māori down with an energy that does not promote good health. The hospital environments were also seen as dirty, and therefore, not conducive to improving your health and wellbeing.

> *Hospitals are a place of sickness and death, so you don't want to be around that if you want to be well. Like there is an energy about hospitals that there is a sickness to it and you don't want to be in the middle of that – you don't get well in the middle of that, you have to be kind of in a living, healthy place. (03:5:14)*

> *He didn't want to go to the doctor, he didn't want to go to the hospital………. Because – a couple of months before he died, his sister died in hospital and I think he – he's thinking now, my sister's*

> *died in hospital, she didn't leave hospital, and now I've got him in hospital, he's not going to come back home…………. (07:1:20)*

> *There's a smell about hospitals and…I don't think hospitals are the most cleanest of places. I think, really you know, like it's a paru [dirty] place to be in, even you know in sleeping in there. (01:2:8)*

> *yeah hospital smells is usually what I think of when I thought of hospitals. Like a sterile smell that there was something underneath it and yeah, I just found that stench kind of scary really. It is a place where people went to die (03:1:1)*

The physical appearance of staff adds further unease to the hospital atmosphere and for one participant awaiting major surgery, reinforced the fear of hospital as a place where you go to die.

> *And she was kind of Gothic as well which unnerved me, she had like black nail polish and dyed black hair and it's wasn't a nice look for a nurse. It was like death was coming to visit my bed* (03:2:6)

Understanding the system

An added stressor to the hospital experience is the difficulty in understanding the hospital systems and its processes. By not understanding what is occurring around them, many Māori may feel disadvantaged. Trying to understand the day-to-day operations of the ward appears to be a significant source of confusion for whānau, for example:

> *I found that if you understand the process and know what is going on, you can achieve things within the system but if you don't, if you have no understanding of how it works, you're at a disadvantage. You're inclined to be pushed into a corner and that's what I discovered. You have to understand the process and you have to have people around you that understand the process if you don't know yourself.* (05:1:4)

> *I think we, as Māori, need to create the processes where we enable our Kaumātua (Elders), our own people, to understand the process. It's not only the elderly, a lot of the young people don't – can't understand the process*. (05:6:6)

> *So we got to know that system inside out, upside down, backwards, not because anybody told us but just because we watched and we were there everyday. We were there ever day, often in the day and we watched and we learned.* (02:10:11)

In some cases, despite getting to know the systems and understanding the processes of the ward routines, confusion exists about decisions made about the treatment of the patient. The confusion was emphasised by not knowing or understanding. If whānau were given information, the staff were not able to explain procedures and treatments in a meaningful way that could be easily understood. Often this leaves whānau in a position of having to interpret the information for the patient, generally with little information themselves about what was occurring:

> *I was getting stressed out, and my brother would come down on the weekend and he would hit the roof. "What the hell's going on, look*

> *our mother’s just wasting away in front of us.” “ She’s not allowed to eat”. And I’d start bawling [crying] and say, “Well, I’m here every day, I’m just doing the best I can, I don’t know what to do, I’m not a doctor”. And he’d say I didn’t mean to make you cry and I’m howling [crying] and he’s howling and we’re howling and we’re trying to hold it together because we don’t want Dad to know we’re worried and Dad’s getting pissed off and going, “What the hell’s going on? Don’t they (the doctors) know what they’re doing? (02:4:6)*

> *And Mum was really agitated and she was – “What are they doing?”……………….. I said, “Mum, they are putting a thing in you to drain water”. That was all I could say, that’s all I understood it to be, I didn’t really know why. (09:1:5)*

In order to know and understand the treatment a patient is receiving involved, in some cases, having to pursue staff, creating a feeling of inconvenience for having to ask for information about their treatment and care. Not receiving information created frustration, and placed whānau in a position where they needed to be assertive when dealing with staff. But by being assertive to get the information, other pressures arise such as an expectation to seek the information in a way that would not be seen to embarrass the whānau:

> *We work in a Pākehā world……… We are confident in that realm, even though medically we don’t know much at all. We’re confident to ask questions and to make people tell us what is going on and to press and press and press…we had a steep learning curve. We knew what questions to ask, we had to learn, we just didn’t have any information unless we probed and moaned at the charge nurse. (02:6:8)*

> *I said, "I want to see a senior doctor here now!" He says, "You can't". I say, "I want to – if you don't I'm going to remove him (son) from this hospital now … I want to talk to that senior doctor now." So he went away and got the senior doctor. (05:2:4)*

> *Not in front of my auntie and uncle but behind the scenes we'd dig the doctors to find out what was going on and we'd dig at the OT's and physios and the nurses and staff behind, but never in front of them because that would just make them even worse. They'd be embarrassed if we did that in front of them. (10:2:18)*

One of the elderly participants wondered if she had been a little more assertive with the staff, she may have seen better care for her husband:

> *Yeah, maybe I wasn't assertive enough to say why isn't he having (a wash) – that did – stick out a little bit to me, is why they weren't giving him a sponge if you like. (07:4:14)*

Discharge bargaining

Because of the alienation and discomfort experienced by the participants while in hospital, many seek to leave hospital as soon as they possibly can and therefore will attempt to bargain with doctors to get out of hospital early:

> *You can actually push and talk a doctor into letting you go, if you can prove to them that you're going to look after yourself – I've done it……………… They've given me my discharge papers but I've bargained with them and said you know, I've pushed to get out, my kids out. So I probably have stayed shorter than what I should have actually.* (04:1:11)

Due to the nature of their illness, for some Māori there is no choice but to stay in hospital. However, as soon as an opportunity to leave arises, then this is taken:

> *But at the earliest opportunity, when they said you know, you might be able to go, I said yes I can. As soon as they thought I was able, possibly able, I said yeah, I want to go.* (03:1:8)

> *And he says, okay, I'll come around and see you at two o'clock, this was the morning rounds – "we'll come around after surgery at two o'clock, if you're okay at that stage, I'll let you go home". I couldn't get out of there fast enough. (*05:1:10)

When some felt they had been in hospital long enough, they sought permission from their doctor to be discharged. Often this involved stretching the truth "a little" in order to convince staff that they were alright to go home:

> *Well, they asked me if I had somebody at home. I said yeah, my granddaughters were there, but my granddaughters had gone back to Auckland……………. Ah, I knew they had gone back, but I just wanted to come home……………I would have found a way of managing. (08:2:9)*

> *I was supposed to have someone with me 24 hours according to the doctors and staff…….. Yeah. But I didn't. I knew they (family) wouldn't be able to do it but I kind of told the doctors, oh, yeah,*

> *yeah. Because there was – the other option was staying in hospital and I wasn't keen on that. I thought also that I could probably look after myself. Like, I didn't feel too bad.* (03:3:9)

Primary carers of relatives were often placed in the unenviable position of having to persuade their relative to stay in hospital to receive the treatment that was needed, even though they know how distressed their relative would be remaining in the hospital environment:

> *She would have let herself out much earlier, we begged her to stay until we found out (what was wrong).* (02:1:16)

> *She would ask, "Oh, when are you going to let me go home?" "Oh, just wait", 'cos we didn't want to bring her back if she was going to get sick again.* (09:2:10)

The hospital environment is a foreign environment often described as a "Pākehā environment", which causes considerable distress for Māori, this leads to Māori feeling alienated and uncomfortable, and emphasises the desire to leave hospital as soon as possible. The following narratives describe family members' attempts to provide ways to make the hospital environment more tolerable, by providing culturally appropriate care and comfort to their family member.

Theme 2: Whānau Caring for Whānau

An overriding theme was the involvement of whānau in patient care - that is, the participants who received care from their whānau while an inpatient or participants who provided cared for their family member who was an inpatient. Those participants who did not have whānau to attend to their personal care went to great lengths to manage their own personal cares as soon as they were able to. Despite the apparent availability of staff to provide care for the patient in most cases, whānau still chose to care for their relative in hospital. The following discussion will describe the concepts of whānau caring for whānau, which will provide insight into why this phenomenon occurs:

The following sub-themes were identified through ‘whānau caring for whānau’. Māori support their whānau while in hospital and by doing so address perceived deficits in their care, sub-themes identified were:

- **Caring for a family member:** describes why whānau choose to care for whānau within the hospital environment
- **Reason to mistrust:** Will examine some of the experiences that provide the rationale for why Māori prefer to have their family care for them in hospital.
- **Quality of care:** describes Māori experiences of hospital care.
- **Don’t complain:** Participants describe why they are reluctant to complain.

Caring for a family member

There was no question regarding who would carry out personal cares while in hospital – it was a family member. Often nursing staff offered to assist Māori patients with their personal cares, but patients would prefer family members to assist with their cares, and in most cases, family preferred to care for their relative. This would mean their relative would be more comfortable, and they were better able to address their physical and cultural needs:

> *I preferred him* [son] *to help me than the nurses. Like, anything I wanted, he would – he was a big awhi* [help] *because he is my own. And, like I felt more comfortable with him than with a nurse. Even though, you know, he is a young man, I still felt comfortable with my own.* (01:1:7)

> *The nurses did offer to come and one actually came in one time and she said she'll wash Mum's bottom half. And Mum said, "Pardon?" And then we told her what she'd said and she (mum) said. "No". Yeah, it was better for her if we did it because that's how she wanted it.* (09:1:6)

> *He (Son-in-law) became very involved in her care because she loved him and accepted him more than she would a stranger and consequently…..he would mirimiri* [massage] *her with moisturisers and things to keep her skin, because it dries out so quickly, they lose hydration. So he would care for her – in hospital was where it had to start because she would rather he did it than have strangers. (02:13:16)*

In some instances whānau felt that they had to address their relative's basic personal needs, because staff appeared to be too busy, but when they did seek assistance from staff, the patient and their whānau felt at times that they were an inconvenience to the staff:

> *We saw how busy they* [nursing staff] *were and how difficult some of the patients were and the families and said don't worry about her. We're sorted. I knew where all the linen was……Yeah, I just went*

> *and helped myself to whatever we needed. Any kind of bathing, showering, anything they wanted us to do we just did ourselves.* (02:9:11)

> *We'd ring the bell and they'd probably be busy and they'd come in and they're just grumpy that you've rung them and you know, that sort of thing. But I don't know if it's 'cos we're Māori or just because of who we are. Just because we are being a nuisance. I didn't feel like I'm being a nuisance.* (05:9:9)

Whānau caring for their relatives within the hospital environment at times found themselves in a situation where they would naturally be "looking out" for other Māori patients on the ward who were usually not related. Participants described situations where they felt it was necessary to support and advocate for other Māori on the ward who may not have family attending to them at the time, either through speaking to staff on their behalf or by providing meaningful information:

> *There was a really nice Māori couple, the day I checked in and he had just had his surgery so he was quite good. He talked me through it, what to expect and stuff. He had had complications though, he had been in there already two weeks or something but he had a lovely wife who was visiting all the patients all through the ward, you know. Especially the Māori patients she was going around making all her connections and who she was related to and stuff, she was really nice. They made me feel quite comfortable. (*03:1:3)

> *I’ve spoken up for kids who aren’t even my kids, brown kids, because - they need to know there’s an aunty sitting across in the other bed that will stand up for them if you’re not doing it right, you know. And I’ll tell the parents when they come in, well they did this and they did that. So I told them this.* (04:1:12)

> *Mind you, at the same time I was in there (hospital), there was a guy along from me and we had the same problem – an elderly Māori chap from Ngāti X (tribe), he didn’t find it so easy because he couldn’t explain. When they asked him for his doctor, he kept referring to the specialist. And then I went along to him and spoke to him in Māori…………and then in a very short time, we had sorted it all out and he was happy and that’s because he couldn’t explain what the problem was with himself and they (staff) were in the dark. (05:3:6)*

Reasons to mistrust

Poor communication by staff and the lack of information provided regarding care and treatment was a frequent problem. Lack of information caused considerable distress, which generated a sense of mistrust. The following narrative is described by a 73-year-old woman when approached by staff to make a decision regarding her husband's resuscitation status. It highlights how poor communication and the lack information provided left her wondering if she had made the right decision, and questioning the actions of staff:

> *They* [staff] *were hounding me and saying, if he went into cardiac arrest, what do I want done. Do I want them to resuscitate him or let him go. I wasn’t ready to answer them. I didn’t want to answer*

> *them………… A nurse came along to me and she said come with me. So I went with her, we went in a room on our own and she hit me with the same question. I thought, well, the longer I keep saying I don't want to know about it, I don't want to give you an answer yet, I thought that the quicker I give her an answer, they're going to leave me alone. So I gave her an answer and I said, well, if he goes into cardiac arrest or whatever, just leave it like that.* (07:2:5)

> *I'm looking at it from another angle now – they thought, here was a man he's down the track a bit in life and maybe he's left it a bit late to look for help……… He was 71. And, like I'm saying, he's left it a bit late to seek help to bring him back on the road to recovery, if you like, and maybe, just maybe they* [staff] *chose to let him go…………………. Yeah.* (07:3:15)

A lack of information provided generates anxiety for both patient and relatives. A family member observed that poor communication by staff with her relative would often lead to altercation and to her relative becoming uncooperative.

> *But from the staff on the ward who were doing the tests and giving her the chemo, she didn't have a clue what they were doing. And she hated injections, she absolutely hated them. So they'd want to come and take blood all the time and they wouldn't communicate with her or joke with her.* (02:5:18)

> *They* [nurses] *do this all the time and the thing is that for us, it's the first time we are going through this, and they don't think about like*

> *it's the first time, and so of course we are going to be asking questions because they don't tell you otherwise.* (01:1:3)

> *They hadn't really told me about potential side effects of the lumbar puncture. They weren't even sure if the lumbar puncture was necessary, they didn't know what was wrong with me. They were just doing it as a precautionary kind of thing they said. I didn't think they gave me enough information about that*. (03:6:10)

Due to the lack of information provided by staff to patients one participant wondered if they were being treated differently because they were Māori, having observed staff interact differently with non Māori on the ward.

> *If you question too much, ……… they get defensive and like I'm a radical standing up for my Māori rights and whatever but I am just standing up for what I know we should be getting which is equal health care. And I wonder how many Māori are in there who would never speak up like me.* (05:14:11)

> *I'm always watching how do they say hello to that parent and how do they say hello to me. You know. It's often not the same if they're a Pākehā.* (05:15:12)

Some actions of staff, led participants to believe that judgements were made that were based on race.

> *There was a lot of staff involved and I felt a sense of judgement there because they didn't think she could read or write or think or –*

> *you know, they were really out of touch with who she was as a person……………. Also I think, maybe because she was Māori and because she wasn't very communicative. Because she was starting to withdraw in that place because they were unfamiliar and not as warm and a little bit more bossy. (02:4:13)*

> *By the time we got in there it had already burst and the doctor, he gave me a hard time about it eh. Like I was a neglectful mother and that's the other thing I find with the hospitals, is they interrogate you, because you're brown. When my kids were babies I used to have to describe what our house was like. Did we have carpet? What sort of furniture did we have?……… (05:1:4)*

Quality of care

The quality of care received was deemed to be at times questionable. Of note was the disbelief in what was observed, placing Māori patients and whānau in a situation where they questioned the quality of care they were observing or experiencing. Along with noticing that their care was not as it should be, one participant felt that staff appeared to be less tolerant of their needs when compared to their experiences of the past.

> *And I think they had given her more and it resulted in her lungs building up with fluid and she couldn't breathe properly so he* [doctor] *told them* [nurses] *to get a catheter in her and straight away, and put her in her own room – like we had been asking but I think they felt she was going to croak (die) they let her have her own room – and then he took me outside and said to me to ring my whānau. You know, to come, because it didn't look as if she was going to make it. But they didn't say that to me, to me it felt like they had made a mistake, the nurses had made a mistake but they didn't say.* (09:2:4)

> *When they come for their rounds, it's a quick – can I feel your tummy, you know, and then they quickly say to the other doctor, if there's a change in medication, what you need and that's about it. It's just, so, you know, so fast. I know there are a lot of patients but for goodness sake, shouldn't there be a better bedside manner.* (11:5:4)

> *I went into hospital fourteen years ago and then two years ago so I found there was a big difference. There just doesn't seem to be as much tolerance for your needs I don't think. I don't know, whether they've just gotten a lot busier……….* (05:3:5)

A sense of abandonment by staff was demonstrated when staff were not seen for long periods of time. One participant timed how long it was between seeing staff, and after an hour and a half stopped as she had to leave.

> *I remember one day with my aunty straight after her amputation, in an hour and a half no-one came in and checked on her………….she went into a four bed room, I once timed it, no-one in that room got seen for an hour and a half……I saw them walking past every now and then but no-one came and checked on any of them and they were all old.* (10:7:20)

> *No, they don't have the time…… I felt like I was looking after myself or they came in once every few hours to just make sure the drip's going or something but yeah, it's quite disgusting.* (11:4:4)

> *I don't know if they were busy, you just never seemed to see anyone around. That was the thing I found the weirdest, it was like there was never anyone around. And you'd talk to the nurses and they'd say oh, we're really busy.* (10:1:8)

Speaking up about the quality of care received, resulted in having to justify concerns, and as described in the following narratives, participants were met with inappropriate and unprofessional responses from staff. One participant explained how she felt she had to be present to "protect" her relative from the staff.

> *He went to take her blood and he kept missing the vein and I – because my kids have had to have drips put in all their lives – and I said to him, oh look, I'd rather get a nurse to do it. And he was like, "what, who do you think you are?" And he got really angry. And he said to me, "what would you like me to do, you'd like me to leave?" And I said I'm just saying this is the third time you've tried to get the thing in and you can't do it, a nurse would be better. Yeah, and he lost it (got upset). "Would you like me to leave"? "Yeah", I said, "I would actually" So felt like I had to be there all of the time to protect her in case one of those people came. (04:1:4)*

> *We tried to ask for a single room for her because the whānau felt that she wasn't going to pull through. Well, that's what they suggested to us so that's why I think she ended up with so many visitors and when we asked for a single room, it was my oldest sister that pushed and pushed and pushed and I wasn't there but she said the nurses ended up yelling at her and saying in front of Mum that there were more important people in the hospital than her. (09:1:3)*

> *And I said to him, "Could you just lower your voice please because there are other people in the room and she doesn't want everyone to know what's wrong with her". And he says, "Oh I'm a doctor". I said "I know you're a doctor but would you mind lowering your voice please because she doesn't want everybody in the room to hear". He said, "We talk about this stuff all the time". I said, "My daughter is the patient". (04:2:6)*

Another issue causing concern was the increasing number of staff working in hospitals that are from other countries. Difficulties with language and cultural misunderstandings place whānau in a position of needing to be translator and cultural protector, to ensure that their relative remains as culturally safe as possible within the already "foreign" hospital environment.

> *There was a nurse, but I don't know what nationality she was but she wasn't Māori. When Mum, when they let her go into her own room……….so I thought maybe they realised Mum had certain sort of cultural needs. I didn't feel that they had that sort of stuff in place when she was there. (09:1:6)*

> *It's being able to understand what the doctor is talking about and a lot of our doctors now are foreign, Indians and all sorts of things. If you don't understand what they are talking about, you are at a disadvantage. And most of our young people going in to see a lot of our clinics, don't understand what they are talking about. (05:1:6)*

> *Most of them were; most of them were (from overseas). I find there's a big blank with the Indians and I'm not against them or anything but they kind of just don't get it eh. They don't get it if you*

> *ask them a question; it takes them a little while to register what you're talking about. Yeah, otherwise they were okay. (04:1:7)*

Don't complain

Despite the experiences of poor quality of care provided to them in hospital, official complaints were not made. The reluctance of Māori to complain about the quality of the care they receive was based on a sense powerlessness and the potential for reprisal by staff. The following narratives demonstrate the lack of trust Māori have in the system.

> *I had found out that I could make a complaint if I wasn't happy with some of the care that Mum received and I spoke to my older sister about it and she said just to leave it because she felt Mum might get alienated next time she goes back (to hospital). (09:1:11)*

> *There were two things that happened but that was probably the worst. And I told – I shared it with a close family member and yeah, she wanted to take them to the cleaners, like get a lawyer and everything and you know, really go in and investigate the whole thing……… for all we know they would have just swept it under the carpet, keep it quiet to save their own – yeah. (06:1:10)*

The previous narratives provide an insight into Māori experiences of hospitalisation and provide examples of how indigenous people are marginalised within the mainstream health care system. The following discussion provides the statistical evidence of Māori average length of hospital stay.

Quantitative Data

McCloskey and Diers (2005) found that when nursing resources were reduced in hospitals, harmful outcomes for patients increased and the average length of hospital stay was reduced. The study examined the effects of health care reforms on the New Zealand health workforce and the subsequent quality of care received by patients within the hospital setting, and noted that over the period from 1989-2006 a 36 percent reduction in nursing FTE’s occurred along with a substantial increase in adverse outcomes and a 20 percent reduction in the average length of hospital stay (McCloskey & Diers, 2005).

Taking into consideration these findings, another study set about to re-examine the effects of health care reforms but concentrating on Māori health outcomes (Wilson, et al., 2008). This study extended on the previous study by analysing administrative data (the National Minimum Dataset) from the New Zealand Health Information Service (NZHIS) for all admissions to public hospitals for the years 1989 to 2004. Along with NZHIS data, nursing workforce data was also examined for the same period, with the aim of determining the effect of nursing on Māori patient outcomes and comparing these findings with non-Māori. A primary objective was to establish if nursing influences the health outcomes for Māori.

A retrospective interrupted time series design was used to identify the differential effects of nursing on Māori patient outcomes in the secondary medical and surgical setting, from 1989-2004. Hospital administrative data was used, examining nursing resources, inpatient mortality, length of stay and 11 outcomes potentially sensitive to nursing. Several questions guided the study; the question most relevant to this thesis asks does the change in length of stay over time follow a pattern for Māori and non-Māori? The information was accessed from the NZHIS for all admissions to public hospitals for the years 1989 to 2004. This standard data is collected from the hospitals electronically by NZHIS, who manage access to the data. The data gathered included the records of all medical and surgical discharges for Māori (identified by a Māori ethnicity being recorded either solely or as one of three ethnicities) and non-Māori from the New Zealand public hospitals. Medical and surgical admissions were screened to include those over the age of 17 years and who had a length of stay greater than 1 day and less than 90 days. Excluded records were those under the age of 17 years and those records with major diagnostic categories in obstetrics, paediatrics and mental health.

Average Length of Stay

Time series data explains how variables change over time (trend), the uniformity of that change (variability) and the range of the variable within which change is occurring (level). Accordingly explanations may address any or all of these types of patterns in the data. Trends are usually indexed with regression slopes calculated in a way that reflects the expected or observed shape of the trend (J. Spicer, personal communication, November 28, 2007). The length of stay over the 15 year period shows a downward trend. The whole population plateaus between the years 1996 and 2002 (Figure 5.1), while Figure 5.2 demonstrates Māori has a parallel downward trend over the 15 year period, but with a persistent length of stay less than non-Māori.

The initial findings relating to the average length of hospital stay (ALOS) demonstrates that since 1989 there has be a gradual reduction in the average length of hospital stay for all populations within New Zealand.

Figure 5.1, shows that in 1989 the average length of hospital stay was nearly 9.5 days, by 2004 the average length of hospital stay reduced to around 7 days. This suggests that during the period of health service restructuring the ALOS was reducing, and this pattern has continued well after the period of the reforms.

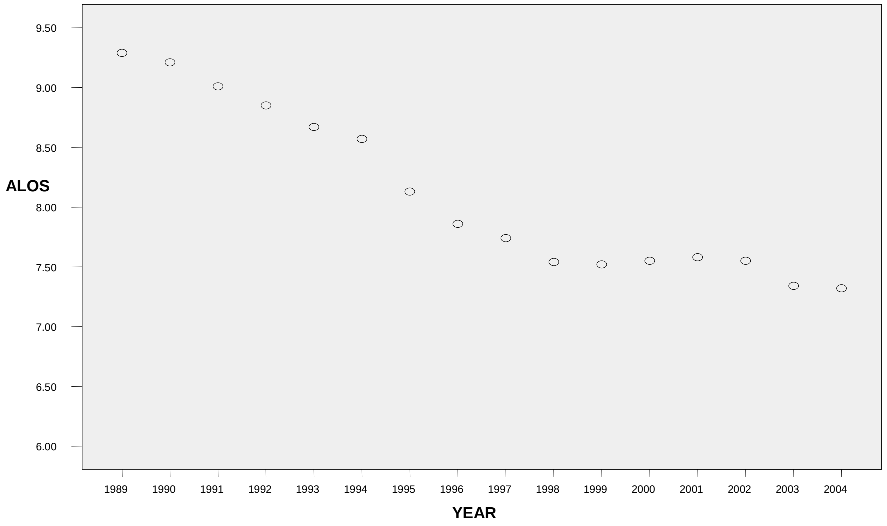

Figure 4.1. Decline of the average length of stay for all populations from 1989 to 2004

Figure 5.2, indicates the average rate of change in ALOS is the same for both Māori and non-Māori over the period from 1989-2004. Of note is that when compared with non Māori, Māori experience a shorter length of stay in hospital for surgical and medical admissions. And that on average Māori are more likely to be discharged nearly 2 days earlier than non Māori.

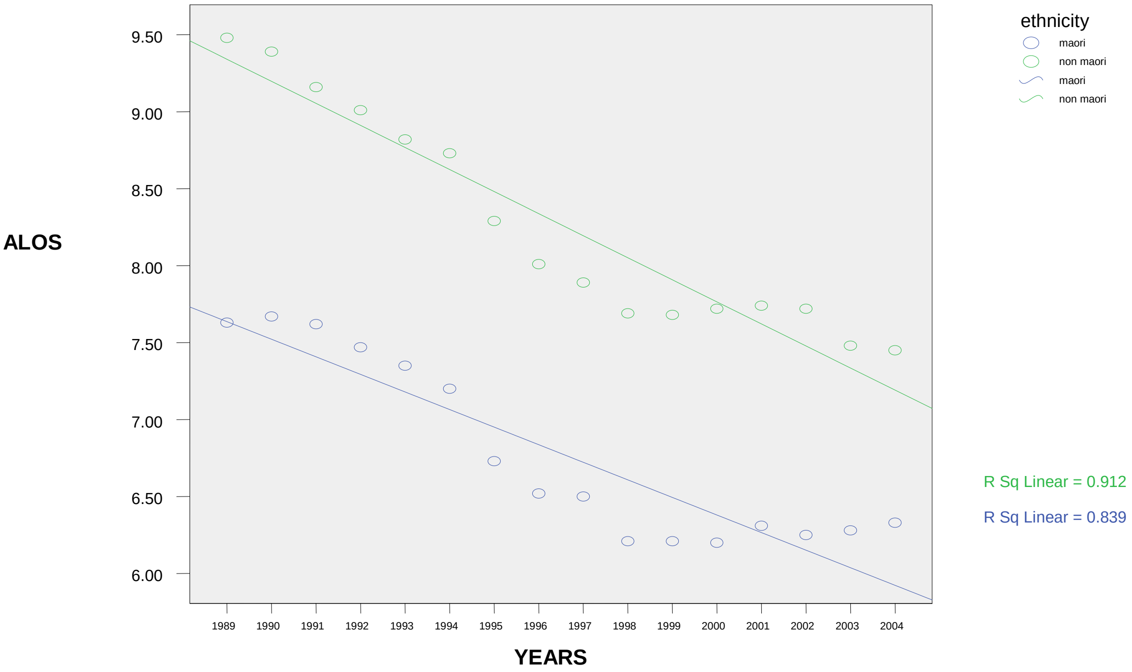

Figure 4.2. Linear summaries of the average length of stay data for Māori and non Māori

Conclusion

The findings from both studies provide a unique insight into Māori experiences of hospitalisation. And provide many examples of how Māori believe the health care system is not meeting their needs, and may provide some insight into their length of hospital stay. The following chapter will discuss and further evaluate the findings, by analysing the narratives of the participants, describing any similarities with international literature relating to other indigenous groups experiences of hospitalisation, discuss the average length of stay findings and finally identify the key interpretations from reviewing all the data.

Chapter 5

DISCUSSION

Introduction

Literature suggests that there is no universally accepted format for writing a case study research report, although there are specific components found commonly in most case studies (Gillham, 2000; Yin, 2003). The report should be richly descriptive, include key participants' statements that reveal significant findings and the strategies used to interpret the report and confirm the case study's findings. The primary characteristic of reporting findings when doing case study research is repetitive, continual review of obtained information to identify answers to questions being investigated. The protocols of triangulation seek to find additional interpretations from the data. A key concept of data analysis in case study research is to develop and modify interpretations from the data, from which conclusions are drawn (Stake, 1995).

The following chapter will begin with analysing the findings from the participant interviews, by revisiting the key themes and discussing the issues that arose through the narratives. Following the analysis of the narratives, international literature relating to indigenous experiences of hospitalisation will be examined within the context of each theme. The chapter will then discuss the findings related to the average length of stay data and finally conclude with the identification of key interpretations from the data analysis.

Interviews and Indigenous literature

Māori experience high morbidity and mortality (MOH, 2006; Robson & Harris, 2007) but despite this research suggests that Māori are in hospital for shorter periods than non Māori (Davis et al, 2006; Wilson et al., 2008). As with other indigenous populations around the world Māori are likely to experience mortality disadvantage when compared with non-indigenous populations (Hill, Barker & Vos, 2007).

The health perspectives of indigenous people do not tend to fit into the simplistic western scientific understanding of health. Māori understandings of health have consistently demonstrated a holistic view that is grounded in Māori ways of knowing and viewing the world (Barton & Wilson; 2008; Durie, 1998; Marsden, 2003; Pere, 1991). For most of the participants, health does not exist independently of other facets of the person, but as part of a myriad of systems that interconnect and are dependent on internal and external forces including whānau (family):

> *I think I approach (health) from a holistic viewpoint so it's not just about the physical aspects of how we are going in our care, it's also about the emotional, psychological and spiritual aspects of care and I think looking after the total person and being caring of ourselves in all of those areas in our lives.(02:1)*

> *Health means to me your wellbeing, looking after your Tinana (body). Health also means the wider picture of looking after your whānau and your wider whānau, so that's the meaning of health*

> *that means to me – just looking after yourself, your tinana, your children and your whānau and your wider whānau.(01:1)*

Minimal international literature exists that specifically describes indigenous experiences of hospitalisation. The literature used in this chapter will relate to both hospital and general health experiences of indigenous people, to gain a better understanding of what other indigenous groups are experiencing and whether their experiences are the same or similar to Māori.

A foreign environment

The term a foreign environment conjures up visions of a far away land, not a hospital ward. But for some of the participants, this term was the best way that they could articulate how their hospital experience felt. Their experience of hospital felt like they had literally left their country and moved to another country. This analogy may seem extreme to many health professionals, but as described by one participant (01:1:3), staff have become so automatic in their interactions that they have forgotten that for many patients the first experience of hospital is akin to entering a foreign land. Despite a lifetime of exposure to the dominant (Pākehā) culture of New Zealand, Māori participants (02:1:20) still felt like they were strangers within the health system and therefore completely alienated.

When participants describe the hospital environment as a foreign environment they are essentially describing, from their understanding, an environment that is Pākehā (New Zealand European origin), that is dominated by western models of care and intervention. For some of the participants the “one culture fits all” philosophy that exists within the hospital exacerbates their sense of alienation and discomfort. The idea that the hospital environment is more conducive to “Pākehā notions of health care" is reiterated throughout the narratives and is a familiar rhetoric amongst Māori in regards to health care services in New Zealand (Caccioppoli & Cullen, 2005; Jansen & Smith, 2006; Reid, Robson & Jones, 2000). Taking into consideration that the hospital environment is considered Pākehā by Māori, it is also important to remember that some older Māori have spent very little time during their lives in a Pākehā environment or even in the company of Pākehā; the social constraints of the past did not encourage such integration. Therefore the experience of sharing a hospital room with a Pākehā can cause considerable discomfort for Māori of that generation.

Feeling that they need to compromise their culture to receive health care is yet another example of how the hospital system caters for Pākehā more than Māori. The fact that it is necessary for a 72 year old Kaumātua (elder) (05:1:12) to remind himself that he is in hospital to receive health care and not for cultural reasons, demonstrates the compromise Māori must undertake in order to receive health treatment, and leads one to ask, how many times has this Kaumātua had to compromise his culture over his lifetime? A mother (04:1:11) describes how she has to get what is needed for her children's health, and then leave as soon as she can for fear of having her children exposed to a culturally insensitive hospital environment. These examples highlight that despite the introduction of cultural safety into the nursing curriculum nearly 20 years ago; it appears that Māori continue to have to "put aside" their culture in order to receive health care. Findings from research by McKinney (2006), found that despite the availability of culturally appropriate Māori support services within hospitals, patients were often not offered the service by nurses and cultural considerations were not included in nursing care planning.

What occurs in the hospital is deemed to be Pākehā practice, and much of what Māori want to do in a hospital is about being Māori, such as having your family and extended family with you continuously, sharing meals, talking, laughing, having a minister or Tohunga provide spiritual comfort and traditional healing practices . As mentioned in a previous chapter the Sir Peter Buck, one of New Zealand’s first Māori medical doctors, made the following observations about Māori and hospital care in the 1930-1940s;

> *A difficulty was experienced in persuading serious cases to enter hospital for treatment. This objection was largely due to the fact that the relatives were not allowed to accompany the patient and sit around the bed indefinitely as they would at home. The limitation to visiting days and hours also made it difficult to satisfy the relatives, who imagined all sorts of catastrophes occurring behind the closed doors.” (Buck, 1966: p 412)*

It appears that the concerns of Māori regarding hospital and western medicine some 60 years ago remain the same concerns experienced by Māori today. This is reflected particularly in the narrative of a mother (04:1:4) who was concerned about the quality of the treatment her daughter was receiving and did not feel it was safe enough to leave her alone, fearing that staff may return and carry out procedures without her consent. Or the participants (06:1:10; 09:1:11) who believed that any complaints made about the quality of the care they received would be “covered up” or result in retribution from staff. A study by Wilson (2004) found that Māori women’s access to and use of health services was hindered by fear and previous negative contact with health services. Many Māori do not have faith in the health system to make them better, and this distrust of the health system is founded when you consider that Māori experience high rates of adverse events within the hospital environment. (Davis, et al, 2006).

> The health system was built by Pākehā according to Pākehā notions of how health care ought to be provided and delivered. It is a by Pākehā for Pākehā system. Little wonder it serves Pākehā better than it serves Māori (Caccioppoli & Cullen, 2005, p14)

When reflecting on the hospital experiences of other indigenous groups, the Māori description of hospital as a "foreign environment" appears to have resonance. An Australian study examining the documented wishes in relation to place of death for Aboriginal people found that not only did Aboriginal people from rural and remote areas want to die at home connected to land and family but many believed that hospital is an alien place and describe feeling unsafe, which caused the patient and carers much fear, distress and hardship (McGrath, 2007).

The notion that hospitals are a "Pākehā environment" where one's culture must be "put aside" so that health care can be received echoes the findings of a Canadian study that examined 10 First Nations women's encounters with mainstream health care services. The participants expressed their sense of being on the outside, as "intruding" and as lacking connection to the social processes that make up the health system. First Nations women believed that their encounters were shaped by "racism, discrimination and structural inequalities that marginalised and disadvantaged indigenous people". (Browne & Fiske, 2001, p.126)

Understanding the system

Another key theme that arose from the narratives was the participant's frustrations with trying to understand the hospital system. Having a grip on the processes and protocols was considered a definite advantage for participants. Of interest was the notion that despite being brought up in a Pākehā environment and/or being exposed to Pākehā ways through work, as was the case with most of the participants, there still existed a frustration around how the system functioned, and attempts made by participants to truly understand what was happening were wrought with difficulty. Much of the difficulty lies within the hospital setting; it creates a "hospital culture", that is predominantly obsessed with power, process, protocols and hierarchy and in turn is patronising and paternalistic (Cram, Smith & Johnstone, 2003).

An excellent example of "hospital culture" was perfectly illustrated by the mother (05:7:6) of a participant who simply asks a doctor to lower his voice while discussing her daughters' case, to which he responds "oh I am a doctor". Hospital culture is further demonstrated when a father (05:2:4) demands to see a senior doctor because of his concern for his son's deteriorating condition, the junior doctor responds with, "But you can't". Examples of nurses involvement in "hospital culture" were also provided by participants, such as insisting a participant (03:2:4) takes pain relief when she doesn't believe she needs it, and the frustration described by the daughter (02:4:13) of a frail terminally ill 82 year old woman, as she witnessed the nurses hound her mother to "rehabilitate". Efforts to rationalise staff responses and actions only confound participants further.

Similar frustrations are described in a study investigating cross cultural hospital care as experienced by Mi'kmaq First Nations community of Canada (Baker & Daigle, 2000). Not only did participants have difficulty understanding the "hospital world" they encountered, such as the rules and regulations, but were confused about their treatment and believed staff would be inconvenienced by their queries. The participants describe that they felt they were strangers within the hospital, often feeling misunderstood and that carers made them feel lessened as a person.

As demonstrated in the narratives, poor communication and lack of information provided to Māori participants by staff exacerbated their sense of alienation. Staff did not communicate in a meaningful way, if they communicated at all, and in some cases patients or family members would have to pursue staff for information. As one participant (05:9:9) wondered when she witnessed staff animosity towards her following a request for assistance; were the staff reacting in this way because she was Māori or because she was being a nuisance?

The findings from a study examining clinical encounters between nurses and First Nations women in a Western Canadian hospital, suggests that because First nations women communicate differently to health care providers, there exists the potential for miscommunication and as a consequence it increases the risk of having their needs overlooked (Browne, 2007). In an Australian study examining the maternity experiences of indigenous woman admitted to an acute care setting, it was found that inadequate interactions and poor communication between staff and Indigenous mothers would often result in misunderstandings or fear (Watson, Hodson, Johnson, & Kemp, 2002).

Quality of care

Davis et al (2006) were unable to determine the specific cause of Māori consistently experiencing poorer quality of care than non Māori in New Zealand hospitals. Along with poorer quality of care Māori also experience higher rates of adverse events and shorter admissions. The quality of care experienced generally by a majority of participants in this study was poor, some participants attempted to explain the reason for their poor quality of care through low staffing levels and priority high need patients. Examples provided through the narratives describe a participant's (10:1:8) experience when caring for her aunt who had recently had a leg amputated, she observed that that her aunt was not seen by a nurse in the hour and half she was there. Another participant (11:4:4) felt as though she was looking after herself, because she hardly ever saw a nurse during her stay. When some participants chose to speak up about the quality of care they were receiving in hospital, they were met with unprofessional responses from staff.

Māori have a constitutional right to equal health care as guaranteed under the Treaty of Waitangi, but despite this Māori experience poor quality health care when compared to non Māori (Davis, et al. 2006; Robson & Harris, 2007). Some participants expressed concern that the quality of care they received was different and believed that their care was poorer because they were Māori. A study determining the association between self reported experience of racial discrimination and health in New Zealand found that Māori reported the highest prevalence of experiencing any forms of racial discrimination. The experience of racial discrimination has been established as a major determinant of health in New Zealand (Harris, et al., 2006).

The narratives of participants provided examples of overt acts of discrimination, such as the situation where a participant (05:8:8) noted how the staff would pull the curtains around the bed of a Pākehā patient when speaking with them, but did not do the same for Māori. And the participant (02:4:13) who felt that nurses had made assumptions about her mother’s ability to communicate, which she believed were based on race. But perhaps it is not just the obvious acts of racism that impact on the quality of care experienced by Māori, but just as likely the omissions and the assumptions made by staff. Questions about the furniture and carpet in her home following the admission of her child to hospital for asthma, led one participant (05:1:4) to consider, was she being asked these questions because of the colour of her skin?

The preliminary findings of an ongoing participatory research study exploring how colonial structures and systems have silenced Canadian Aboriginal women’s voices and how this has affected the ways in which urban Aboriginal women seek health services identified that some of the women in the study experienced outright racism, and found that the colour of the participants skin determined the type of treatment they received—the darker their skin, the worse their encounter or the more negative the assumptions made by health care providers (Kurtz, Nyberg, Tillaart, Mills, OUAHRC, 2008). Racial discrimination experienced by Canadian Aboriginal women is manifested by the actions and assumptions of some health care and social service providers, that Aboriginal women are unfit mothers based on racist stereotyping, and due to the actions of government agencies in the past many Aboriginal mothers fear that their children may be removed from their homes for unjust reasons (Browne & Fiske, 2001; Browne & Varcoe, 2006; Kurtz, Nyberg, Tillaart, Mills, OUAHRC, 2008).

Dodgson and Struthers (2005) examined ways in which Native American women experienced marginalisation in health and found that participants did not trust mainstream health services and health care providers were often viewed as disrespectful because of abruptness, inattention and unauthentic demeanour. When participants encountered such health workers they found it more difficult to trust what they advised and were hesitant to provide in-depth information to the health worker. Many participants felt that their voices were not heard in the mainstream health care system. Some participants said health care providers did not understand the hardships faced by their people. (Dodgson & Struthers, 2005)

Whānau caring for whānau

Participants expressed a mistrust of the health system and a belief that the health system was not going to address their health needs. These beliefs are founded when considering evidence that Māori experience poor quality of care, high rates of adverse events and discriminatory practices within mainstream health services (Davis et al, 2006; Harris et al., 2006; MOH, 2006; Robson & Harris, 2007; Wilson et al, 2008). The narratives indicate that when a Māori person is in hospital, it is likely that the family will provide their personal cares, such as showering, washing and toileting. Māori prefer to care for their relatives in hospital because they are assured that their family member will receive culturally appropriate care. As some participants explained, it was better if family just carried out the personal cares. Putting the cultural aspect aside, other participants describe addressing the personal cares because staff were too busy and were concerned that things might not get done.

A consequence of Māori preferring to care for their own in hospital is the assumption by staff that <u>all</u> Māori will carry out the personal cares of their relative. As described by one participant (07:4:14), when she noticed her husband's feet were dirty and realised that he had not had a wash since arriving in hospital. Her husband was so acutely unwell she believed that the staff would tend to his personal cares; she wondered if perhaps she had been more assertive, staff would have washed her husband before he died.

None of the literature relating to indigenous hospital experiences described the Māori practice of providing direct cares for the family member in hospital, although there were references to family visiting, supporting and wanting to be involved in decisions. Similar to Māori practices, the Australian Aboriginal family gathers together when an individual family member is experiencing illness - so if one family member is in hospital, the whole family remains with them until the person improves based on the belief that constant family support aids the recovery process. Garvey, Towney, McPhee, Little, and Kerridge, (2004) suggested that such large gatherings of family can be both puzzling and intimidating to non-Aboriginal Australian health workers and lead to cultural misunderstandings.

Whānau caring for their relatives within the hospital environment at times found themselves “looking out” for other Māori patients on the ward who were usually not related. Māori participants describe that they felt it was necessary to support and advocate for other Māori on the ward who may not have family attending to them at the time. One participant (03:1:3) describes being the recipient of such support, and therefore made to feel more comfortable in the hospital environment. A similar experience is described by a participant of the Mi’kmaq First Nations community of Canada (Baker & Daigle, 2000). The person felt afraid in hospital, and then he discovered a fellow Mi’kmaq person in the room next door and felt reassured through talking with him. Baker and Daigle, (2000) suggested in this scenario the participant created a “cultural umbrella” in the foreign hospital environment.

Discharge Bargaining

When asked about their discharge from hospital many of the participants describe complete desperation to leave as soon as they can. Some participants described how they have initiated their discharge, others have had to persuade doctors to allow them to leave, and some admitted to having to lie, to reassure staff that they were capable and prepared to return home. None of the participants self discharged against medical advice. None of the participants described being discharged from hospital before they felt ready, although it is necessary to consider as previously, that their discharge could occur without the knowledge or realisation that in fact they are leaving considerably earlier than others that have had similar procedures or diagnosis.

Would such an insight make a difference to Māori initiating their discharges, when taking in to account negative contributing factors, such as the environment and the quality of care? Indications from the narratives suggest that it probably wouldn’t make a difference. Whether a discharge is initiated by Māori or by their physician, the fact that Māori want to leave hospital as soon as they can does need to be considered when reflecting on the Māori length of stay in hospital. This raises the question if Māori are leaving hospital earlier than non Māori, is it actually detrimental to their health or their recovery? This is a question that needs to be considered within the context of another study.

Minimal international literature exists relating to the indigenous hospital length of stay and discharge experiences. Although in the Canadian study examining the Mi’kmaq peoples hospital experiences (Baker &Daigle, 2000), participants felt that the hospital environment created feelings of aloneness and insecurity, it “didn’t fit with non native society”, and like the Māori participants, some Mi’kmaq participants responded by withdrawing into themselves, while others actually left hospital early or wanted to but were too unwell.

According to the Australian Ministry of Health and Ageing (2008) the average length of stay for an Aboriginal and Torres Strait Islander patient was 5.8 days compared with 6.5 days for non indigenous patient in a public hospital admission. Although the difference between Aboriginal and Torres Strait Islander’s average length of stay and other Australians is not as substantial as the difference between Māori and non Māori, the statistics indicate that despite the high morbidity and mortality rates of the Aboriginal and Torres Strait Islanders, like Māori, are leaving hospital earlier, whether through their own accord or through discriminatory practices.

Literature discussing indigenous experiences of hospitalisation provides insight into the phenomena from an international perspective and identify that what Māori are experiencing when they enter a hospital is similar to the experiences of other indigenous people. Unfortunately due to the lack of international literature, it is difficult to know if, how Māori cope with their experiences while in hospital, (i.e. whānau caring for whānau and discharge bargaining) is a uniquely Māori response or also a response likely to be shared by other indigenous or marginalised people.

Quantitative findings

The findings from the quantitative data raised the initial question about what are Māori experiences of hospitalisation. Evidence has proven that Māori experience high rates of morbidity and mortality when compared to non Māori (Blakely et al, 2004; Blakely, Tobias & Atkinson, 2008; Cormack, Purdie, Robson, 2007; Curtis, Harwood & Riddell, 2007; Harwood & Tipene-Leach, 2007) therefore it would be natural to conclude that Māori would require longer hospitalisation than non-Māori. But research indicates that not only do Māori have higher needs for hospitalisation, particularly surgical interventions, but they are less likely to receive them. If they do receive surgical interventions, Māori are more likely to be discharged earlier than the non-Māori patient in the bed next to them (Ministry of Health, 2006; Robson & Harris, 2007; Westbrooke, Baxter & Hogan, 2001).

McCloskey and Diers (2005) suggested that the quality of hospital experiences can be linked to adverse events and also to nursing practice.

This was demonstrated when nursing resources were reduced in hospitals during the health reforms of the 1990s and subsequently harmful outcomes for patients increased. But particularly in relation to this study, McCloskey and Diers suggested also that the quality of hospital experiences can also be linked to length of stay.

The narratives gathered to understand Māori experiences of hospitalisation suggest that having overcome their anxieties related to hospital and agreed to hospital treatment, many of the participants experienced an environment that reinforced their negative beliefs about hospitals and health professionals. Most participants did not have faith in the hospital services to meet their health needs, and described experiences of personal and cultural isolation, poor communication and quality of care, racism and discrimination. Despite the turbulent history of providing health care to Māori in New Zealand, the public health care system continues to provide a hospital environment that marginalises it indigenous people. For this reason it is understandable that Māori would choose to leave such an environment as soon as they possibly can.

Interpretations

Data triangulation seeks to corroborate the same fact or phenomenon from multiple sources of evidence (Stake, 1995). Yin (2003) suggests that the advantage of using multiple sources of evidence in case study research is the development of converging lines of inquiry (triangulation), ensuring that any findings or conclusions are likely to be more convincing and accurate if it is based on several different sources of evidence. In case study analysis there are few fixed formulas to guide the researcher; instead, researchers must use their own style of rigorous thinking and present sufficient evidence and consider carefully alternative interpretations.

Through the converging of qualitative and quantitative data, it was possible to draw some conclusions relating to Māori experiences of hospitalisation. Three key interpretations have emerged: 1) Māori are marginalised in the New Zealand health system; 2) Māori do not believe that the hospital environment is conducive to healing. 3) Māori experiences in hospital contribute to their decision to leave as soon as possible (Figure 5.1). The following discussion will explain the relationships between the data and further define these interpretations.

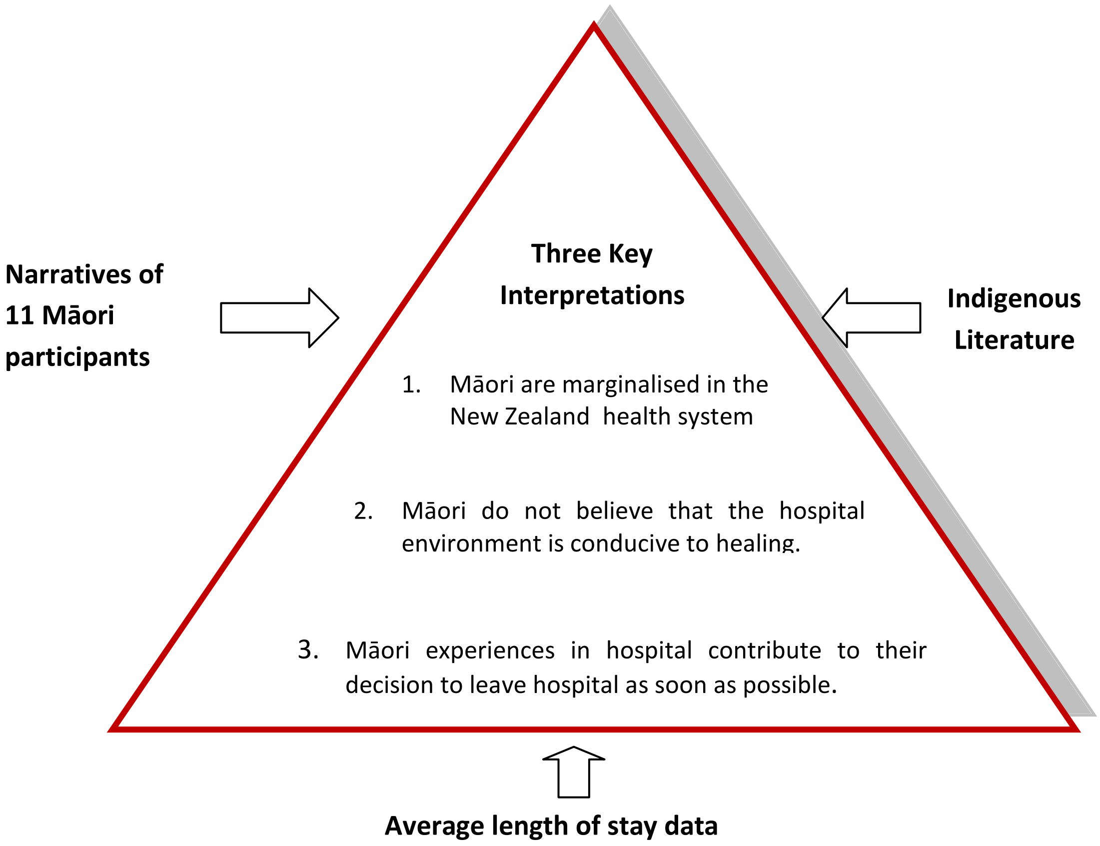

Figure 5.1. Key interpretations about Māori experiences of hospitalisation from the triangulation of the data

Interpretation 1: Māori are marginalised in the health care system

> *The death thing isn't something that I struggle with (in hospital), it's more the cultural misunderstanding that they're not treating me the same as other patients and that my kids aren't going to get the same (04:1:12)*

The narratives gathered from the participants provided a unique insight into Māori experiences of hospitalisation. The similarities of the experiences of Māori to other indigenous people highlighted that the phenomena is not exclusive to Māori. Combining these findings with the average length of stay data and it is evident that Māori, like other indigenous groups around the world (Browne & Fiske, 2001; Dodgson & Struthers, 2005), continue to be marginalised in New Zealand society despite their tangata whenua status (indigenous people of New Zealand) and equal rights as guaranteed to them under the Treaty of Waitangi.

Māori marginalisation occurs at all levels of the political, economic, social and health sectors. Dodgson and Struthers (2005) explained that different values create a boundary between the mainstream culture and the indigenous worldview, which could be viewed as protective or as marginalizing. Meleis (1996) further suggests that understanding the worldview of those marginalised is the first step toward creating a culturally competent health service. Wilson (2008) reiterates this view but suggests also that culturally appropriate health services should go beyond relationship building and into respecting the worldviews and cultural preferences of indigenous people, factors that are essential for developing trust.

Marsden (2003) maintains that ‘despite cultural erosion and genocide as imposed by colonialist processes tangata whenua has never totally surrendered the core beliefs and value systems of their culture’ (p.34). Māori ‘cultural erosion and genocide’ has occurred since the first Pākehā stepped on shore. Over the following 160 years Māori have endured the decimation of their people through exposure to disease, the loss of their lands through war, confiscation and legislation, the depletion and pollution of natural resources, and the active suppression of their culture through government legislation. Māori have had to adapt to the changing environment around them, moving away from the rural tribal lands and communities and into the cities. But despite living, working and socialising in a predominantly western society, many Māori, whether rural or urban based, still retain their cultural values and core beliefs.

Māori core beliefs and value systems are embedded in mātauranga Māori (Māori ways of knowing) and Te Ao Mārama (a Māori worldview) (Royal, 1998). Traditional Māori worldviews and knowledge are founded on wholism, an Iwi (tribal) based social system, and an oral tradition (Cunningham, 1998). Traditional Māori values and beliefs, practices and customs and the Māori language have survived the impacts of colonisation and urbanisation, and are a testament to the tenacity of the Māori people (Barton & Wilson, 2008).

The boundary that exists between the Pākehā culture and the Māori worldview is no more evident than in the New Zealand health care system. Meleis (1996) explained that marginalisation is evident when groups are placed on the periphery of society based on race, sexual orientation, socio-economic circumstances and national origin. When marginalisation occurs people are stripped of their voice, power and rights to resources. Marginalisation is demonstrated by the dominance of the western scientific model within the hospital environment and the inability for mainstream health service providers to adapt their services to increase meaningful Māori participation in service development and delivery. Wilson and Neville (2008) explained that the social context integral to the lives of vulnerable and marginalised people is ignored within the health care environment and suggest that the concept of holism in nursing practice is merely a rhetorical construct. Health providers need to understand the historical and contemporary socio-political context of Māori, and adapt to accommodate Māori values, beliefs, customs and practices within the delivery of health services (Barton & Wilson, 2008; Dodgson & Struthers, 2005).

Interpretation 2: Māori believe that the hospital environment is not conducive to their healing

> *Māori have their own beliefs about how you get well and stuff – hospitals don't really incorporate Māori healing and medicine into it. I mean, everything is done in a Pākehā kind of western way and while people recognise that that works, they also know that there is other ways so that being there is not the be-all and end-all of it. I mean, personally, I just have a distrust of them, it's just rituals and stuff – it's their belief system (03:3:13).*

As previously explained, health perspectives of indigenous people do not tend to fit into the simplistic western scientific understanding of health. Māori understandings of health have consistently demonstrated a holistic view that is grounded in Māori ways of knowing and viewing the world. For most of the participants health does not exist independently of other facets of the person, but as part of a myriad of systems that interconnect and are dependent on internal and external forces including whānau (Cram, Smith & Johnstone, 2003; Durie, 1997; 2001; Wilson, 2004)

Traditional Māori health interventions are still an integral part of Māori culture, practices such as rongoa Māori (Māori medicine), mirimiri (Massage), karakia (prayer) and the significance of Tohunga (Traditional healer) and the whānau (family), all continue to play a significant part in Māori health. None of these practices are routinely available to inpatients; if a Māori patient does wish to use any traditional medicines or carry out any traditional healing practices then often they will wait until they return home, averting a refusal or reproach from staff when asking for permission to use traditional medicines in hospital. Often the hospital environment does not provide the safety (both spiritual and physical) to carry out traditional practices.

Māori primary health care services have been developing over the last 20 years following the government's decision to decentralise health care and allow non government community agencies to vie for contracts (Durie, 2001; Ellison-Loschmann & Pearce, 2006). Many of the Māori services provide primary health care and traditional Māori healing practices together, and have incorporated the traditional beliefs and values into the work ethos. As a consequence many Māori now choose to seek primary health care from Māori health providers (Ministry of Health, 2006). Yet Māori concepts of health care and treatment are obvious by their absence in the secondary and tertiary health care sector. At this time there exist no specific Māori facilities or services that address the medical and surgical needs of Māori in a culturally appropriate way.

The question then would be, if such a facility were available to Māori would it be utilised? The concept of continuing to provide secondary and tertiary health care within the confines of a hospital ward needs to be seriously reassessed. To provide secondary health care to Māori with an environment that is conducive to healing may mean providing an environment that is completely Māori which of course means for mainstream services thinking literally ‘outside the box’.

Interpretation 3: Māori experiences in hospital contribute to their decision to leave as soon as possible

> *But it did bother me that they were so insensitive to issues around the body. Particularly for women and the sacredness of that and how unfamiliar it is to have a stranger’s hands anywhere near your body and touching you in private places, or washing you or seeing you in that state….. And that’s sad, that they would put men (male nurses) with Māori elderly women, they just have no idea. (02:4:16)*

The accumulated data from this case study research suggests that marginalisation within the hospital and beliefs that the hospital environment is not conducive to healing contribute to Māori desire to leave hospital as soon as possible. If Māori have to stay in hospital then often Māori will attempt to make the best of the situation by providing direct care to their relative, providing ‘cultural comfort’ or by seeking out meaningful information. The diagram below has been adapted from Wilson (2004) and demonstrates the most likely responses from Māori depending on the situation that they encounter in hospital.

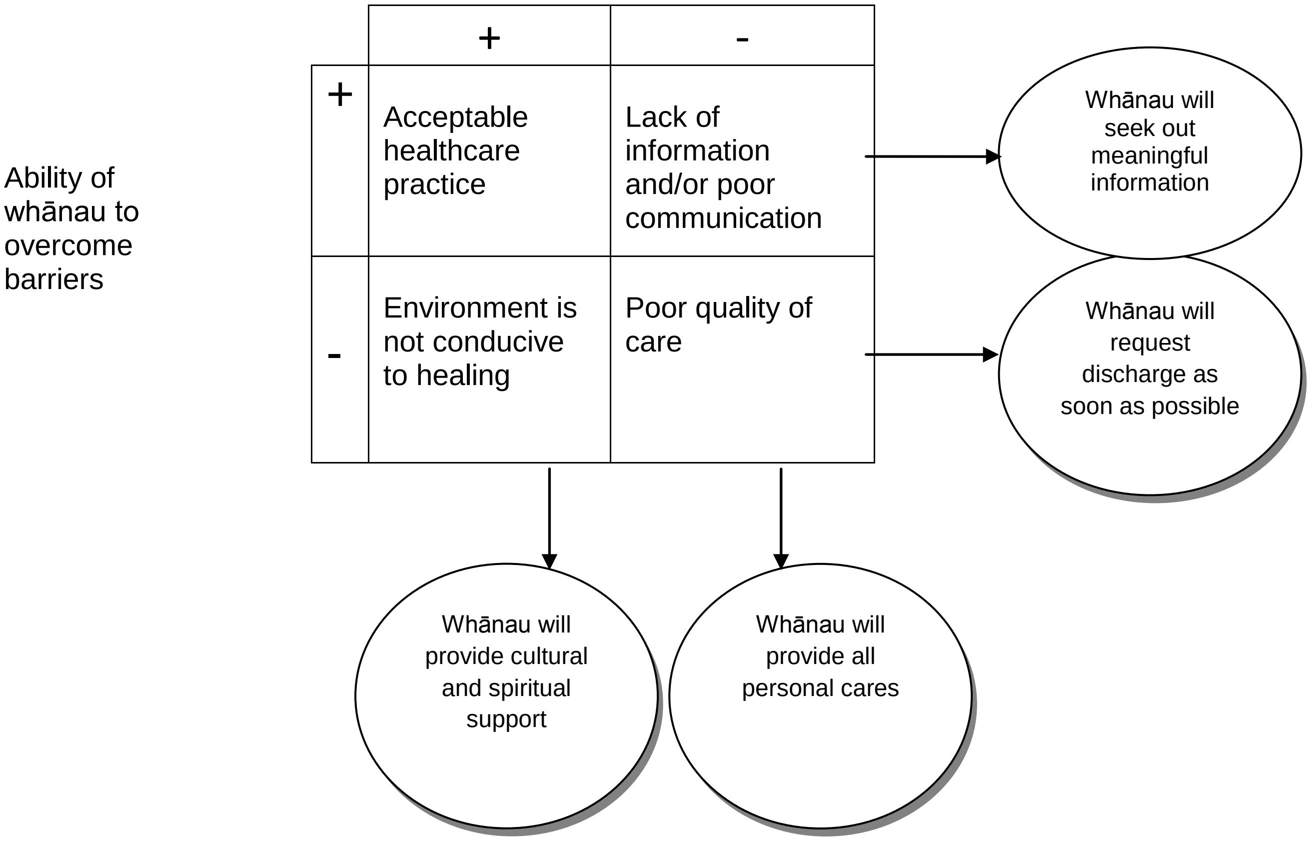

Figure 5.2: Health seeking behaviours of Māori

Note. Adapted with permission from Wilson (2004)

Conclusion

An intrinsic single case study design (Stake, 1995; Yin, 2003) was used to understand Māori experiences of hospitalisation, the intrinsic design allowed for the identification of everyday actions and interactions within the health care environment. Multiple sources of evidence were gathered that included quantitative statistics, interviews of participants, and international literature relating to indigenous experiences of health care.

The advantage of using multiple sources of evidence is the converging lines of inquiry (triangulation). Yin (2003) suggested that through the process of triangulation any findings or conclusions are likely to be more convincing and accurate because they are based on different sources of information.

Themes evolved from the saturation of the collected information and separate and distinct categories of findings were identified, each theme was specific and explanatory. Eventually through the analysis of all the data key interpretations were developed and conclusions were drawn (Stake, 1995). The interpretations provide an understanding of Māori experiences of hospitalisation and provide some interesting insights into the Māori average length of hospital stay.

The ability to generalise these findings to other groups are limited by the qualitative nature of the interviews, the size of the participant group and that predominantly the participants were female.

The following chapter will briefly summarise each chapter within this thesis and consider the implications for nursing practice and health care services, concluding with recommendations.

Chapter 6

CONCLUSION

Introduction

This chapter will begin with a review of the research aims and outcomes, followed by a summary of the key points of each of the previous chapters, then a discussion regarding the findings and the implications for nursing practice and health care provision. Finally the chapter will conclude with recommendations.

When Māori enter hospital for a medical or surgical intervention, they are more likely to be discharged earlier than non-Māori. (Davis et al., 2006; Wilson et al., 2008). The differences in the average length of hospital stay (ALOS) data and my observations of my whānau receiving treatment as inpatients led to this research study. Māori experiences within mainstream health services in New Zealand had rarely been investigated. Understanding what occurred when a Māori patient was admitted to hospital was a key aim of this research project. The research question eventually asked: What are Māori experiences of hospitalisation? The aims of the research hoped to capture a comprehensive perspective of the participant’s lived experiences within the context of their everyday lives and particularly within the hospital setting. The aims therefore set about to:

1. Understand Māori health related values, beliefs and experiences
2. Understand the Māori experience of hospitalisation

3. Understand how Māori experiences of hospitalisation may relate to the length of stay

Minimal literature exists that truly provides insight into Māori hospitalisation experiences both from an historical perspective and a contemporary view. Therefore, it was necessary to begin by examining the historical context of Māori health. Chapter 2 began by investigating the history of Māori health prior to and following colonisation, current Māori health status was described and disparities in morbidity and mortality presented. The determinants of Māori health outcomes were also examined, recognising the factors that influence the health of Māori. The health outcomes of other indigenous people were discussed through international literature from Australia, Canada and the USA, identifying that the indigenous people from other countries experienced poor health outcomes and health disparities similar to Māori. The history of Māori and hospitalisation was described including the change in hospital admission rates. Some of the most recent literature relating to Māori health service utilisation and hospitalisation was defined. Finally the chapter concluded with a discussion on Māori and nursing, describing the evolution of the role of nursing in New Zealand and the influences on Maori health historically and the influence of nursing on Māori health today. This chapter set the scene for the research, laying the foundations for the subsequent chapters.

Chapter 3 described the methodology that was used to develop this research study. Because the research study was to include Māori it was important to use a methodological process that would be respectful of Māori. The methodological principles for Kaupapa Māori research are described so that the reader could understand the basis for the use of Māori centred research. Māori centred research as with Kaupapa Māori research employs a Māori methodology and analysis, the difference being that the methods and analysis were employed alongside western/mainstream methods and utilised mainstream analysis. Māori centred research was utilised alongside a Case study research methodology.

Case study research is best used in situations where little is known about what is going on, and when it is necessary to “get under the skin” of a group, also to ‘view a case from the inside out’, which is what was required to understand Māori experiences of hospitalisation, it enabled research into the ‘processes’ around Māori hospitalisation rather than into the causes or reasons for hospitalisation itself (Gillham, 2000). Through Case study methodology the researcher was able to present richly descriptive information from several sources and therefore allowed the voices of the participants to be heard. The use of multiple sources of information helped to develop a ‘true picture’ of Māori experiences of hospitalisation and view the subject from different standpoints (triangulation). This process of triangulation suggests that any findings or conclusions are likely to be more convincing and accurate if it is based on several different sources of information (Yin, 2003). Data collection processes were described and analytical procedures defined. Finally the chapter concluded with a description of the ethics and limitations of both methodologies.

Chapter 4 provides the findings from both the participant interviews and the quantitative analysis. The participant interviews had been analysed by examining, categorising, tabulating and constantly recombing the narratives to address the initial questions and aims of the study. Each case was initially analysed individually, then an analysis was made across the cases. Analysis involved identifying the frequency of themes or events in the narratives. Reoccurring themes were then listed by relativity to the research topic and frequency. Up to 10 sub themes were identified, themes included ‘the hospital environment’, ‘understanding the system’, ‘discharge bargaining’, ’caring for a family member’, ‘reasons to mistrust’, ‘quality of care’ and ‘don’t complain’. The themes were then categorised in to two overarching themes:

- Theme 1: A foreign environment, and
- Theme 2: Whānau caring for whānau.

Participant dialogue was used to substantiate each theme. The findings from the quantitative data provide insight into average length of hospital stay for both the general population and for Māori, and graphs were used to illustrate the differences in ALOS.

Chapter 5 begins by analysing the findings from the participant interviews, through revisiting the key themes and discussing the issues that arose through the narratives. Issues such as the cultural inappropriateness of the hospital environment and the need for Māori to have to compromise their culture in order to receive treatment are some of the issues defined through the analysis process. Following the analysis of the narratives, international literature relating to indigenous experiences of hospitalisation was described and similarities were discovered between Māori and other indigenous groups. A discussion ensues related to the average length of stay data and finally the chapter concludes with the identification of key interpretations from the data analysis. The interpretations include:

1. Māori are marginalised in the health care system.
2. Māori believe that the hospital environment is not conducive to their healing.
3. Māori experiences in hospital do contribute to their decision to leave as soon as possible.

The following section will discuss the implications of the research findings for nursing practice and health service provision, and will include recommendations.

Implications for nursing practice

Wilson (2003) believes that nurses have a role to build on the strengths of indigenous people so as to improve their health outcomes. Nurses provide health care within an environment that marginalises its indigenous people and until the health care system changes, and a service more conducive to Māori health beliefs and practices is developed, nurses need to adapt the way that they practice when working with Māori within the existing hospital system. By providing healthcare to Māori in a respectful and collaborative way opportunities will arise for health professionals to have a positive impact on the health of Māori (Cram, Smith, & Johnstone, 2003; Wilson, 2003).

1. Cultural safety

Cultural safety was introduced in to the New Zealand nursing curriculum in the early 1990s. It was seen as an ideological shift driven by the desire to change the power relations that exist within health care interactions, to shift the power from the nurse to the patient (Richardson, 2004). The philosophical expectation of cultural safety was that of power sharing, yet despite the rhetoric there exists no evidence to suggest that this has occurred (Cram, Smith, & Johnstone, 2003; McKinney, 2006; Wilson 2004; Wilson & Neville, 2008). Wilson and Neville (2008) explain that populations that are marginalised and/or vulnerable, such as indigenous and elderly people, are placed between the rhetoric of nursing and the reality of nursing care.

Recommendations

The original intention and purpose of cultural safety has become weighed down by rhetoric, and the ideology is lost and confused by the time a new graduate nurse walks onto a hospital ward. The Nursing Council of New Zealand needs to be seen to be more proactive around improving Māori health outcomes. A review of the whole undergraduate nursing curriculum needs to occur so that it incorporates Māori values and beliefs into all areas of nursing education. Such a review would be considered a serious attempt by the Nursing Council to address Māori health inequalities. Establishing a bi-cultural philosophical foundation and moving away from the dominant euro-centric paradigm that saturates nursing schools throughout Aotearoa/New Zealand can only be beneficial for the future of nursing and Maori health.

2. Cultural competence

Cultural safety in practice is demonstrated through culturally competent nursing care. Registered Nurses need to demonstrate cultural competency within their scope of practice by providing evidence that they are 'practicing in a manner that the client determines as being culturally safe' (Nursing Council of New Zealand, 2007). But it is proposed that the ability to accurately and reliably understand and demonstrate cultural competence makes it difficult to measure (Richardson, 2004). Wilson (2008) explains that there are measurable elements that would be deemed an essential part of any cultural competence assessment, these include aspects such as the nurses' knowledge, beliefs and attitudes, their ability to integrate a client's culture in to their practice and that their actions are seen to be improving health outcomes for Māori. The New Zealand

Nursing Council clearly does not request such elements to be demonstrated by nurses seeking cultural competence.

Recommendations

A dual competency framework- *Huarahi Whakatū*- has been developed and implemented to assess the cultural and clinical competency of (predominantly Māori) nurses working with Māori in Māori mental health services (Maxwell-Crawford, 2004). I understand the need for such a competency framework when nursing within a Kaupapa Māori environment. A dual competency framework similar to Huarahi Whakatū, needs to be developed for use by all nurses working in mainstream health services, such a framework could be aligned with the bi-cultural undergraduate nursing education formerly proposed. Nurses would therefore have an established foundation of knowledge, beliefs and attitudes, and have the skills and confidence to integrate them into practice. Again such a programme would need to be recognised by Nursing Council and included as part of any Professional Development Recognition Programme (PDRP).

3. Developing “A cultural umbrella”

In chapter 5 Baker and Daigle, (2000) describe a scenario where a Mik’maq patients fear and anxiety about hospitalisation was relieved upon discovering a fellow tribal member in another room; they explained that the tribal members developed a ‘cultural umbrella’ within the foreign hospital environment. A similar scenario was described by several participants from this study, who described ‘looking out’ for other Māori on the ward. Unless there is a sudden change of the dominant culture and worldview in New Zealand, the mainstream hospital system is going to continue to provide secondary and tertiary health care to Māori. The idea of a ‘cultural umbrella’ or a ‘cultural space’ within existing mainstream services may help to make hospital less of a foreign environment for Māori.

Recommendations

Simple changes in health care practice could make an uncomfortable situation more comfortable, such as putting Māori patients together in the same room, provide Māori staff to care for Māori patients if they are available, provide gender appropriate staff particularly to the elderly, and accommodate and provide space for Māori cultural practices including space for whānau. These changes in nursing practice don't require large amounts of resources, funding or even in-service education, but do require staff to be creative in their management of the ward environment.

Cultural competence in nursing practice has been complicated by the rhetoric of cultural safety; nurses need to understand that simple changes in their health care practice can contribute to positive health experiences and outcomes for Māori people. The following table (Table 6.1) describes how nurses, doctors and other health care workers can work more effectively with Māori within the existing hospital environment.

Table 6.1

RAPUA: SEEKING to minimise the impact of marginalisation on Māori in mainstream health services.

Respect	Respect for a persons cultural values, beliefs and practices.
Acceptance	Accepting that many Māori have a world view that differs from the dominating world view of western society.
Patience	Being patient and acknowledging that Māori processes are different and may not fit into the bio-medical model of the hospital environment
Understanding	Understanding that the hospital environment is a predominantly Pākehā environment and Māori are entering an environment that has values and beliefs that are very different to their own Understanding the historical and contemporary socio-political context from which Māori have evolved.
Advocacy	Advocacy is about the nurse/health professional providing information to colleagues and supporting Māori to be Māori within the hospital environment.

Note: The mnemonic 'rapua' means 'to seek' in Māori.

Implications for Health care services

To recommend a total restructure of the health system so to provide a health service that is more conducive to Māori health and ways of viewing the world is idealistic and probably unrealistic at this time in New Zealand. Current Māori health statistics indicate that Māori will continue to have little choice but to utilise existing mainstream secondary and tertiary health services in to the future. Therefore, it is necessary for mainstream health care service providers to understand that the service they provide marginalises and disadvantages Māori.

1. Integration of Culturally Acceptable Interventions

Meleis (1996) suggested that the challenge for health care providers is to hear, acknowledge and value the experiences of marginalised groups so that they are better able to bridge the gaps between cultures, minimise misunderstanding and provide culturally competent care. There is a desperate need for secondary and tertiary health care services to consider how they deliver culturally competent care and how Māori values and beliefs could be integrated into service delivery to improve the health experiences of Māori.

Recommendations

Cultural competence needs to also be assessed at service provider level. Caccioppoli and Cullen (2005) provide four examples of how a service provider can be assessed as culturally competent when working in Māori health.

1. They seek to identify institutional barriers to equal health outcomes for Māori and advocate with Māori for their removal.

2. That the service looks critically at its own systems and attitudes with the aim of detecting those which disadvantage Māori.
3. As part of their continuing professional development, the service commits to involvement in the local Māori community.
4. The service recognises that it costs more to achieve the same health gain in Māori and commits to devoting that additional resource to Māori health. (p.152)

Health service providers of secondary health care are predominantly District Health Boards (DHBs) in New Zealand. As with non-government health service providers, DHBs must provide some evidence of cultural competence, and must be accountable to the Māori communities they service. Implementing strategies to improve Māori participation in secondary and tertiary health care service development and delivery would be seen as a positive move towards minimising the effects of marginalisation within mainstream health services.

He moemoeā, He wawata – A dream, A vision

A vision for the future is that of a secondary health care service by Māori, for Māori, that provides holistic health care, integrates the patient's culture into their care, is culturally safe, appropriate and grounded in Māori ways of knowing and viewing the world.

Tēnā koutou, tēnā koutou, tēnā koutou katoa. Tihei Mauri ora!

REFERENCES

Anderson, I., Crengle, S., Leialoha Kamaka, M., Chen, T.-H., Palafox, N., & Jackson-Pulver, L. (2006). Indigenous health in Australia, New Zealand, and the Pacific. *Lancet, 367*, 1775-1785.

Armstrong, F. (2004). 'Deadly': Indigenous health today. *Australian Nursing Journal, 12*(5).

Awjani, S., Blakely, T., Robson, B., Tobias, M., & Bonne, M. (2003). *Decades of disparity: Ethnic mortality trends in New Zealand 1980-1999*. Wellington: Ministry of Health and University of Otago.

Baker, C., & Daigle, M. (2000). Cross cultural hospital care as experienced by Mi'kmaq clients. *Western Journal of Nursing Research, 22*(1), 8-28.

Barton, P. & Wilson, D. (2008). Te Kapunga Putohe (The restless hands): A Māori centred nursing practice model. *Nursing Praxis in New Zealand, 24 (2), 2-15.*

Bevan-Brown, J. (1998). By Māori, for Māori, about Māori - Is that enough? In *Proceedings of Te Oru Rangahau* (pp. 231-246). Palmerston North: Massey University.

Bhopal, R. (2006). Racism, socioeconomic deprivation, and health in New Zealand. *Lancet, 367*(9527), 1958-1959.

Bishop, R. (1997a). Interviewing and collaborative storying. *Education Research and Perspectives, 24*(1), 28-47.

Bishop, R. (1997b). Māori peoples concerns about research into their lives. *History of Education Review, 26*(1), 25-41.

Blakely , T., Ajwani, S., Robson, B., Tobias, M., & Bonne, M. (2004). Decades of disparity: Widening ethnic mortality gaps from 1980-1999. *New Zealand Medical Journal, 117*, 995-1015.

Blakely , T., & Robson, B. (2003). Health gaps who's to blame? *Kai Tiaki: Nursing New Zealand, 9*(11)*,* 19.

Blakely, T., Tobias, M., & Atkinson, J. (2008). Inequalities in mortality during and after restructuring of New Zealand economy: Repeated cohort studies. *British Medical Journal, 336*, 371-375.

Blakely, T., & Wilson, N. (2006). Shifting dollars, saving lives: What might happen to mortality rates, and socio-economic inequalities in mortality rates, if income was redistributed? *Social Science & Medicine, 62*(2006), 2024-2034.

Bolitho, S., & Huntington, A. (2006). Experiences of Māori families accessing health care for their unwell children: A pilot study. *Nursing Praxis in New Zealand, 22*(1), 23-32.

Bramley, D., Herbert, P., Jackson, R., & Chassin, M. (2004). Indigenous disparities in disease-specific mortality, a cross country comparison: NZ, Australia, Canada and the USA. *New Zealand Medical Journal., 117*(1207).

Bramley, D., Riddell, T., Crengle, S., Curtis, E., Harwood, M., Nehua, D., et al. (2004). A call to action on Māori cardiovascular health. *New Zealand Medical Journal, 117*(1197), U957.

Browne, A. (2007). Clinical encounters between nurses and First Nations women in a Western Canadian hospital. *Social Science & Medicine, 64*, 2165-2176.

Browne, A., & Fiske, J. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research, 23*(2), 126-147.

Browne, A., & Varcoe, C. (2006). Critical cultural perspectives and health care involving Aboriginal peoples. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 22*(2), 155-167.

Buck, P. (1966). *The coming of the Māori*. Wellington: Whitcombe and Tombs.

Caccioppoli, P., & Cullen, R. (2005). *Māori health*. Auckland: Kotahitanga Community Trust

Carr, J., Robson, B., Reid, P., Purdie, G., & Workman, P. (2002). Heart Failure: Ethnic disparities in morbidity and mortality in New Zealand. *New Zealand Medical Journal, 114*, 15-17.

Chin, M., Walters, S., Cook, S., & Huang, E. (2007). Interventions to reduce racial and ethnic disparities in health care. *Medical Care Research & Review, 64*(7).

Close, B. (2005). Walking in two worlds: There are some significant differences between the qualities required of a Māori nurse leader and those who identify as Pākehā. *Kai Tiaki: Nursing New Zealand, 11*(2), 21-22.

Collings, S., & Ellis, P. (1997). Biological, social and economic risk factors. In M. Ellis & S.Collings (Eds) *Mental Health in New Zealand from a Public Health perspective* (pp 39-82). Wellington: Ministry of Health.

Cormack, D., Purdie, G., & Robson, B. (2007). Cancer. In B. Robson & R. Harris (Eds.), *Hauora: Māori standards of health IV* (pp. 103-119). Wellington: Te Roopu Rangahau hauora o Eru Pomare.

Cram, F., Smith, L., & Johnstone, W. (2003). Mapping the themes of Māori talk about health. *The New Zealand Medical Journal, 116*,1-7.

Cunningham, C. (1998). *A Framework for addressing Māori knowledge in Research, Science and Technology.* Paper presented at the Te Oru Rangahau Māori Research and Development Conference, Massey University, Palmerston North.

Curtis, E., Wright, C., & Wall, M. (2005). The epidemiology of breast cancer in Māori women in Aotearoa New Zealand: Implications for ethnicity data analysis. *The New Zealand Medical Journal, 118*(1209), 1297-1307.

Curtis, E., Harwood, M., & Riddell, T. (2007). Cardiovascular disease. In B. Robson & R. Harris (Eds.), *Hauora: Māori standards of health IV* (pp. 140-158). Wellington: Te Roopu Rangahau Hauora o Eru Pomare.

Davis, P., Lay-Yee, R., Dyall, L., Briant, R., Sporle, A., Brunt, D., et al. (2006). Quality of hospital care for Māori patients in New Zealand: retrospective cross-sectional assessment. *Lancet, 367*, 1920-1925.

Dodgson, J., & Struthers, R. (2005). Indigenous women's voices: Marginalization and health. *Journal of Transcultural Nursing, 16,* 339-346.

Durie, A. (1998). *Me Tipu Ake te Pono: Māori Research Ethicality and Development.* Paper presented at the Te Oru Rangahau Māori

Research and development Conference, Massey University, Palmerston North.

Durie, M. (1998). *Whaiora: Māori health development* (2nd ed.). Auckland: Oxford University Press.

Durie, M. (1997). Whānau, Whanaungatanga and Healthy Māori Development. In P. Te Whaaiti, M. McCarthy, & A.Durie, (Ed.), *Mai i Rangiaatea: Māori wellbeing and development*. Auckland: Auckland University Press with Bridget Williams Books.

Durie, M. (2001). *Mauri Ora: The dynamics of Māori health*. Auckland: Oxford University Press.

Durie, M. (2004). *Exploring the Interface between science and indigenous knowledge.* Paper presented at the 5th APEC Research and Development Leaders Forum, Christchurch, New Zealand.

Durie, M. (2005). *Nga Tai Matatuu: Tides of Māori endurance*. Melbourne: Oxford University Press.

Dyall, L. (1997). Māori. In Collings, S., & Ellis, P. (Eds.), *Mental Health in New Zealand from a Public Health perspective* (pp. 85-103). Wellington: Ministry of Health.

Ellison-Loschmann, L., & Pearce, N. (2006). Government, politics, and law. Improving access to health care among New Zealand's Māori population. *American Journal of Public Health, 96*, 612-617.

Garvey, G., Towney, P., McPhee, J. R., Little, M., & Kerridge, I. H. (2004). Is there an Aboriginal bioethic? *Journal of Medical Ethics, 30*, 570-575.

Gauld, R. (2003). One Country, Four Systems: Comparing Changing Health Policies in New Zealand. *International Political Science Review, 24*(2), 199-218.

Gillham, B. (2000). *Case study research methods*. London: Continuum.

Hancock, D., & Algozzine, B. (2006). *Doing case study research: A practical guide for beginner researchers*: Teachers College Press, New York.

Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: Cross-sectional study. *Lancet, 367*, 2005-2009.

Harwood, M., Aldington, S., & Beasley, R. (2005). Lung cancer in Māori: A neglected priority. *118, 1410-1412*.

Harwood, M., & Tipene-Leach, D. (2007). Diabetes. In B. Robson & R. Harris (Eds.), *Hauora: Māori standards of health IV* (pp.160-167). Wellington: Te Roopu Rangahau hauora o Eru Pomare.

Henry, P., & Pene, H. (2001). Kaupapa Māori: Locating indigenous ontology, epistemology and methodology in the academy. *Organization Speaking Out, 8*(2), 234-242.

Hill, K., Barker, B., & Vos, T. (2007). Excess indigenous mortality: are Indigenous Australians more severely disadvantaged than other indigenous populations? *International Journal of Epidemiology, 36*, 580-589.

Horton, R. (2006). Indigenous peoples: time to act now for equity and health. *Lancet, 367*(9524), 1705-1707.

Howden-Chapman, P., & Cram, F. (1998). *Social, economic and cultural determinants of health*. Wellington: National Health Committee.

Jansen, P., & Smith, K. (2006). Māori experiences of primary health care: breaking down the barriers. *New Zealand Family Physician,* 33(5), 298-300.

Jeffreys, M., Stevanovic, V., Tobias, M., Lewis, C., Ellison-Loschmann, L., Pearce, N., et al. (2005). Ethnic inequalities in cancer survival in New Zealand: Linkage Study. *American Journal of Public Health, 95*, 834-837.

Keefe, V., Cram, F., Ormsby, C., & Ormsby, W. (1998). *Representing the 'other' when they're our relations*. Wellington: Te Roopu Rangahau Hauora a Eru Pomare.

Kerr, G. D., Gamble, G. D., Doughty, R. N., Simmons, D., & Baker, J. (2006). Mortality in individuals with Type 2 diabetes and heart disease in a unique New Zealand population. *Diabetic Medicine, 23*, 1313-1318.

King, M. (2003). *The Penguin history of New Zealand*. Auckland: Penguin.

King, M. (2005). *Te Puea: A life* (New Edition ed.). Auckland: Reed.

Kurtz, D., Nyberg, J., Tillaart, S., Mills, B., & OUAHR Collective (2008). Urban Aboriginal women speak out about their experiences with health care. *Journal of Aboriginal Health, 4*(1), 55-63.

Lange, R. (1999). *May the people live: A history of Māori health development 1900-1920*. Auckland: Auckland University Press.

McCloskey, B., & Diers, D. (2005). Effects of New Zealand's health reengineering on nursing and patient outcomes. *Medical Care, 43*, 1140-1146.

McCreanor, T., & Marim, R. (2002). Tauiwi General Practitioners' Explanations of Maori Health: Colonial Relations in Primary Healthcare in Aotearoa/New Zealand. *Journal of Health Psychology, 7*(5), 509-518.

McGrath, P. (2007). Aboriginal cultural practices on caring for the deceased person: Findings and recommendations. *International Journal of Palliative Nursing, 13*, 418-425.

McKegg, A. (1991). *'Ministering angels' : the government backblock nursing service and the Māori health nurses, 1909-1939.* Unpublished Master of Arts (History), University of Auckland, Auckland.

McKillop, A. (1998). *Native health nursing in New Zealand 1911-1930: A new work and a new profession for women.* Unpublished Masters of Arts in Nursing, Massey University, Palmerston North.

McKinney. (2006). *Māori experiences of hospital care in Auckland.* Unpublished Masters of Public Health, The University of Auckland, Auckland.

Marsden, M. (2003). *The woven universe: Selected writings of Rev. Māori Marsden*. Otaki: Te Wananga o Raukawa.

Maxwell-Crawford, K. M. (2004). *Huarahi Whakatū: Māori mental health nursing career pathway*. Palmerston North: Massey University.

Mead, L. T. (1996). *Nga Aho o te Kakahu Mātauranga: The multiple layers of struggle by Māori in Education.* University of Auckland, Auckland.

Meleis, A. (1996). Culturally competent scholarship: substance and rigor. *Advances in Nursing Science, 19*(2), 1-16.

Ministry of health, & University of Otago. (2006). *Decades of disparity III: Ethnic and Socioeconomic inequalities in mortality, New Zealand 1981-1999*. Wellington: Ministry of Health.

Ministry of Health. (2006). *Tatau Kahukura: Māori health chart book, Public Health Intelligence Monitoring Report No.5*. Wellington: Ministry of Health.

Ministry of Health and Ageing. (2008). Part 6: Indigenous Australians in hospital. In *State of our public hospitals report*: Ministry of Health and Ageing.

Nairn, R., Pega, F., McCreanor, T., Rankine, J., & Barnes, A. (2006). Media, racism and public health psychology. *Journal of Health Psychology, 11*(2), 183-196.

National Advisory Committee on Health and Disability. (2002). *Improving Māori health policy*. Wellington.

National Health Committee. (1998). *The social, cultural and economic determinants of health in New Zealand: Action to improve health*. Wellington: National Health Committee.

Newbold, K. B. (1998). Problems in search of solutions: Health and Canadian Aboriginals. *Journal of Community Health, 23*(1).

Nursing Council of New Zealand. (2005). *Competencies for the registered nurse scope of practice.* Wellington.

Papakura, M. (1938). *The old time Māori*. Hong Kong: Condor Production.

Pere, R. (1991). *Te Wheke: A celebration of infinite wisdom*. Wairoa: Ao Ako Global Learning New Zealand.

Powick, K. (2002). *Māori research ethics: A literature review of the ethical issues and implications of kaupapa Māori research and research involving Māori for researchers, supervisors and ethics committees.* Unpublished A literature review, Waikato University, Hamilton.

Reid, P., Robson, B., & Jones, C. (2000). . Disparities in health: Common myths and uncommon truths. *Pacific Health Dialog, 7*(1), 38-47.

Reime, B., Tu, A., Lee, S., & Canadian Neonatal Network. (2007). Treatment differences between Aboriginal and white infants admitted to Canadian neonatal intensive care units. *Paediatric and Perinatal Epidemiology, 21*, 532-540.

Richardson, S. (2004). Aotearoa/New Zealand nursing: from eugenics to cultural safety. *Nursing Inquiry, 11*(1), 35-42.

Riddell, T. (2005). Heart failure hospitalisations and deaths in New Zealand - patterns of deprivation and ethnicity. *The New Zealand Medical Journal, 118*(1208), 1254-1264 .

Ring, I., & Brown, N. (2003). The health status of indigenous peoples and others. *BMJ: British Medical Journal,* pp. 404-405.

Robson, B. (2004). *Economic determinants of Māori health and disparities: A review for Te Roopu Tohutohu I te Hauora Tūmatanui (Public Health Advisory Committee of the National Health Committee)*. Retrieved September, 2005, from http://www.nhc.govt.nz/PHAC/publications/ecdets.doc

Robson, B., Robson, C., Harris, R., & Purdie, G. (2007). Hospitalisations. In B. Robson & R. Harris (Eds.), *Hauora: Māori standards of health IV* (pp. 62-101). Wellington: Te Roopu Rangahau Hauora o Eru Pomare.

Robson, B., & Harris, R. (Eds.). (2007). *Hauora: Māori standards of health IV. A study of the years 2000-2005.* Wellington: Te Roopu Rangahau Hauora a Eru Pomare.

Royal, C. (1998a). *Mātauranga Māori: Paradigms and politics.* Paper presented at the Ministry of Research, Science and Technology, Wellington.

Royal, C. (1998b). Te Ao Mārama: A research paradigm. In *Proceedings of Te Oru Rangahau* (pp. 79-87). Palmerston North: Massey University.

Smith, G. H. (1990). *Research issues related to Māori education.* Paper presented at the NZARE Special Interests Conference, Education Department, University of Auckland.

Smith, G. H. (1992). *Tane-nui-a-rangi's legacy...propping up the sky: Kaupapa Māori as resistance and intervention.* Paper presented at the NZARE/AARE Joint Conference, Deakin University, Australia.

Smith, L. T. (1999). *Kaupapa Māori methodology: Our power to define ourselves.* Paper presented at the seminar for the School of Education, University of British Columbia.

Smith, L. T. (1999). *Decolonizing methodologies; Research and indigenous peoples*. Dunedin, New Zealand: Otago University Press.

Stake, R. E. (1995). *The art of case study research*. California: Sage.

Te Puni Kokiri. (2000). *Progress towards closing social and economic gaps between Māori and non-Māori*. Wellington: Ministry of Māori Development.

Watson, J., Hodson, K., Johnson, R., & Kemp, K. (2002). The maternity experiences of indigenous women admitted to an acute care setting.. *Australian Journal of Rural Health, 10*(3), 154-160.

Westbrooke, I., Baxter, J., & Hogan, J. (2001). Are Māori under-served for cardiac interventions. *The New Zealand Medical Journal, 114*, 484-488.

Wilson, D. (2003). The nurse's role in improving indigenous health. *Contemporary Nursing, 15*(3), 232-240.

Wilson, D. (2004). *Nga Kairaranga Oranga: The weavers of Health and Wellbeing.* Unpublished A Grounded Theory Study, Massey University, Palmerston North.

Wilson, D. (2008). The significance of culturally appropriate health services for indigenous Māori women. *Contemporary Nurse, 28*(1-2), 173-188.

Wilson, D., Diers, D., Carryer, J., Spicer, J., McCloskey, B., Barton, P., Budge, C. (2008). Māori hospitalisation and adverse outcomes: A retrospective time series study. *Unpublished*.

Wilson, D., & Neville, S. (2008). Nursing 'their way' not 'our way': Working with vulnerable and marginalised populations. *Contemporary Nurse, 27*(2), 165-176.

Yin, R. (2003). *Case study research design and methods* (Third edition ed. Vol. 5). USA: Sage.

Appendix I

INTERVIEW SCHEDULE

Interview Schedule

Age: Male/Female Urban/Rural Iwi:

Tell me what health means to you……………..
Tell me what illness means to you……………....
How important is your health in relation to other issues in your life?

What was your experience of hospital before your first admission?
Had other whānau members been in hospital?
Tell me more about that.

Think about the last time you were in hospital. Tell me about what happened.
Did you think you needed to go to hospital and why?

Was your family present while you were in hospital?
Did the staff keep them informed of what was happening with you?

When you were on the ward, did you feel you were being kept informed of what was happening?
Any procedure that was carried out
Explained things so that you could understand
Explained why you needed to receive treatments

Was the staff approachable and helpful?
Who provided your personal cares while you were in hospital?

Tell me how you were able to practice your cultural and spiritual beliefs?
Was this important for you?

Did you feel you were treated the same as the other patients on the ward?
Please explain...

Tell me about your discharge from hospital.
Did you ask to be discharged or did you wait for the doctor to say when you could go?

How was it for you when you went home?

What do you expect when you visit a doctor or hospital for care?
Is it important to you that staff has some understanding of Māori culture?

Recent research has found that Māori have a shorter time in hospital for medial and surgical admissions than non-Māori patients. Can you tell me why you think that there could be a difference?

Is there anything else you would like to share with me about your hospital experience and going home?

Based on the following definitions how would you describe your cultural identity?

☐ I have access to Te Reo, Māori land, Whānau & the Māori world
☐ I have a strong sense of being Māori but limited access to Māori cultural and social resources
☐ I describe myself as Māori but do not have anything to do with things Māori
☐ I do not describe myself as Māori but have good access to the Māori world

Appendix II

ETHICS APPROVAL

Massey University
AUCKLAND

OFFICE OF THE ASSISTANT
TO THE VICE-CHANCELLOR
(Research Ethics)
Private Bag 102 904
North Shore 0745
Auckland
New Zealand
T 64 9 414 0800 extension 9539
F 64 9 414 0814
humanethics@massey.ac.nz
www.massey.ac.nz

22 May 2008

Pipi Barton
c/- Dr D Wilson
College of Humanities and Social Sciences
Massey University
Albany

Dear Pipi

HUMAN ETHICS APPROVAL APPLICATION – MUHECN 08/031
"Why are medical/surgical stays shorter for Maori than for non-Maori?"

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Dianne Gardner
Deputy Chair
Human Ethics Committee: Northern

cc: Dr D Wilson
College of Humanities and Social Sciences

Appendix III

CONSENT FORM

Why are medical/surgical hospital stays shorter for Māori than for non-Māori?

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I wish/do not wish to have my tapes returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed:

Name:

Date:

Appendix IV

INFORMATION SHEET

Why are medical/surgical hospital stays shorter for Māori than for non-Māori?

Tēnā koe, my name is Pipi Barton and I will be the researcher for this project. I am a student at Massey University studying for a Masters of Nursing with a special interest in Māori health. The completion of this research project is needed so that I can finish my study. I am currently employed, as a Research Assistant for Massey University. My supervisor will be Dr Denise Wilson; she is employed as a Lecturer and Māori Health Co-ordinator in the School of Health Studies at Albany campus. Both my supervisor and myself are of Tainui descent.

I would like to invite you to participate in an interview with me about your beliefs about health and experiences of being in hospital. I am also seeking the views of whānau who have supported a relative in hospital, and asking them to complete a questionnaire. If you agree to participate, I will meet with you to answer any questions you may have, and decide where, when and how you wish to talk about your experiences. The interviews can be held in your own home or at a venue that I can arrange. If at any time you feel you no longer want to be part of the study then you are able to withdraw at any time. The interviews will be audio-recorded and should take no longer than an hour and a half.

The interview will be recorded and then transcribed, removing all identifying features to ensure your anonymity. The transcriber will be required to sign a confidentiality agreement. A copy of the typed information will be returned to you to check to ensure it is accurate. Excerpts of the interviews may be used in writing up my thesis. A summary of the findings will be sent to you, if you so wish. You will be informed of where copies of the full research can be found. The findings of the research will also be presented at conferences and written in publications. Copies of my thesis will be stored at Massey University Library.

If you agree to participate in this research every endeavour will be made to protect your confidentiality, and any identifying information removed in the transcripts and my thesis and any publications. I will store all tapes and transcripts in a secure cabinet; at the completion of the study all transcripts will be securely stored at Massey University for ten years, when my supervisor will be responsible for their destruction. I will, however, offer you the tape recording of the interview if you wish, otherwise I will destroy it.

Participation in this research is entirely voluntary, and you are under no obligation to do so. Should you choose to participate in the study your have the right to:

- Refuse to answer any questions.
- Withdraw from the project up until one week after the interviews have been completed.
- Ask any questions about the research at any time during its course.
- Provide information on the understanding that your name or any identifying features will not be used.
- Read and check a copy of your interview transcript.
- Turn off the tape at anytime during an interview.
- Be given access to a summary of the findings when the research is completed.

You can contact me by writing to:
C/- Dr Denise Wilson
School of Health & Social Services

You can contact my supervisor Dr Wilson by writing to:
School of Health & Social Services

Massey University- Auckland Campus
Private Bag 102 904
North Shore Mail Centre
Auckland 0632
By telephone on: 09 441 8166
My email is:

Massey University – Auckland Campus
Private Bag 102 904
North Shore Mail Centre
Auckland 0632
By telephone on: 09 441 8166 extn 9070
By email: D.L.Wilson@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 08/03. If you have any concerns about the conduct of this research, please contact Dr Dianne Gardner, Acting Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email humanethicsnorth@massey.ac.nz.