MĀORI WHĀNAU EXPERIENCE OF HOSPITAL TRANSFERS

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Māori Whānau Experience of Hospital Transfers

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Abstract

In Aotearoa, Māori have significantly worse health outcomes than Pākehā (Robson & Harris, 2007). The differences in these health statistics become visible through the proportion of Māori healthcare service users and the numbers of hospital admissions for Māori compared to non-Māori (Robson et al., 2015). Research is fairly scarce in terms of the experiences Māori have within the hospital system and literature is currently non-existent with regard to Māori experiences of hospital transfers. Since Māori link culturally appropriate care with quality of care it is imperative that the climate of these experiences is explored, particularly with reference to the interactions that Māori have with staff and services (Wilson & Barton, 2012). Within the present study an interpretive phenomenological analysis (IPA) was conducted with 22 transcripts with Māori whānau. These whānau were either patients who underwent a hospital transfer to Waikato Hospital within the 12 months prior to recruitment in 2017 or support people throughout this process. From this analytic process came four prominent themes; there was a lack of cultural competency of staff which was underpinned by anther ancillary theme, negative stereotypes and assumptions about Māori. Alongside these two themes there was also a lack of information dissemination by staff and barriers to effective interpersonal communication between staff and Māori whānau. The emergent themes mentioned led to several recommendations for future policy including the need for ongoing cultural competency training for staff and for this cultural competency to be evaluated by Māori, for Māori and with Māori. Information should also be more proactively and effectively disseminated to whānau.

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Chapter 1: Introduction

The present research attempts to shed light on the experiences of Māori *whānau* (family) within the hospital transfer process particularly as they pertain to the interactions with staff and services. This research question is central to the hospital transfer project's overarching focus aimed at understanding how whānau remain engaged in the care of a loved one.

The following report will include a review of the current literature as it pertains to Māori experiences of hospital transfers and interactions within the system. The methodological approach will then be outlined and will include both an epistemological position and the methods of data analysis. Findings will be presented in the following section and will be supported by a subsequent discussion. To conclude, recommendations will be detailed from the findings of this research.

Literature Review

The following literature review will attempt to contextualise the scope and background of the present study. To begin with there will be a section on Māori health and hospitalisations to give a broad context to the following study. The next section will cover challenges to healthcare that have been outlined in previous research, an overview of reported staff and service interactions within the overall Aotearoa health sector. Subsequently, there will be an acknowledgement and exploration of the ways in which these challenges are being sought to be overcome.

Māori Health and Hospitalisations

Māori are overrepresented in most negative health metrics and have been suffering from substandard health since European settlement led to radical changes and societal upheaval for Māori in the 1800s (Ministry of Health, 2013; Robson & Harris, 2007; Woodward & Blakely, 2014). This disproportionate representation stems from a long history of colonisation, land confiscation and flawed systems that do not meet the rights and responsibilities of the government to Māori outlined in Te Tiriti o Waitangi (Consedine & Consedine, 2001). With most Māori-owned land being alienated in the 1890s through calculated governmental legislation, and the passing of continuous laws that sought to undermine Māori society and strip guaranteed citizenship rights, it is clear that Te Tiriti was not respected as it should have been (Consedine & Consedine, 2001). Ongoing breaches have not only systematically impacted Māori communities in a political and social manner. They are also considered a catalyst for adverse effects on Māori health and wellbeing.

For a significant period of time, these effects were considered trivial to many non-Māori, though they were an inescapable reality for Māori themselves (Tobias, Blakely, Matheson, Rasanathan & Atkinson, 2009). In 1975 the Treaty Act was introduced and was the first piece of modern legislation to officially recognise the importance of Te Tiriti o Waitangi (Barrett, Connolly-Stone, 1998) Since the 1970s Te Tiriti breaches have been increasingly recognised and redress has started to occur, though it has taken a detrimental period of time, and the impacts remain widespread and pervasive throughout societal systems (Tobias, Blakely, Matheson, Rasanathan & Atkinson, 2009). Despite their effect on Māori whānau, these impacts can often be difficult to ascertain by the unaffected majority.

The impacts on Māori whānau are reflected in the disproportionate rates of health conditions for Māori (Robson & Harris, 2007). Māori have higher rates of diabetes, heart disease, asthma and many other health conditions compared with non-Māori. These health conditions, along with others, can require both acute and prolonged hospitalisation. Between 2011 and 2013, Māori hospitalisation admissions were 16% higher than non-Māori during the same period (Robson et al., 2015). As Māori make up such a significant proportion of health service users, it is therefore imperative that this system is culturally appropriate and supports the overall healing process for the patient and the wider whānau.

Challenges of Healthcare

Māori conceptualisations of health are detached from the biomedical model that is strictly adhered to within the public healthcare system here in Aotearoa and elsewhere in the Western world. The biomedical model is rooted in the biological medicalisation of health problems, which is a concept Māori tend to reject (Durie, 1998). This is in stark contrast to the more holistic and interwoven Māori notions of health. The Te Whare Tapa Wha model of health outlines four essential facets of well-being, including *taha wairua* (the spiritual side)*, taha hinengaro* (thoughts and feelings)*, taha tinana* (the physical side) and *taha whānau* (family) (Durie, 1998). These four dimensions are all interrelated and are valued for the contribution they make to overall wellbeing. These two conceptualisations of health are unquestionably quite distinct and they do not neatly superimpose in a way that is helpful for Māori whānau.

It is also important to acknowledge that the health system, and other institutions that Māori are now interacting with have not always been conventional or ordinary (Durie, 1998). Traditional practices and values of health such as the use of *karakia* (prayer), the consultation with t*ohunga* (professional experts), *mirimiri* (massage) and *rongoā* (physical remedies) were used at a more mainstream level for Māori before the establishment of the public healthcare sector (Durie, 1998). Since the public health system's establishment within Aotearoa, and the infamous

Tohunga Suppression Act of 1907, Māori health practices were increasingly attacked and side-lined in favour of the Western biomedical model (Dow, 1999). Despite this legislation at the turn of the 20th century, these practices have a continued strength with one in eight Waikato Māori taking part in traditional healing in 2015 (Robson et al., 2016). There is a clear tension between these ideologies of health and many believe that the two are incompatible with one another (Cram, Smith & Johnstone, 2003). While the biomedical model undoubtedly has its benefits for the health of Aotearoa, it has to be acknowledged that there are limitations such as these compelling tensions between the two that cannot be ignored.

Another challenge of healthcare for Māori is that the present model prioritises the individual rather than the group. Māori are a collectivist culture and the health of individuals is seen within the integrative context of the extended whānau and *hapu* (kinship group or subtribe). The prioritisation of these individualistic values within the healthcare system, dismisses Māori values and displaces them from their key roles in the healing of their whānau member. The differences in these understandings creates a strain within the system that poses further issues for Māori.

Another major challenge for Māori health that becomes evident within the literature is the reluctance to access or seek help. Each year over 5000 Māori hospital admissions are considered potentially avoidable, and this number could perhaps be reduced through earlier intervention (Robson et al., 2015). These statistics are often tied to the idea of resistance and the subsequent blame of non-compliance. The reality however is rather different (Wilson, 2008). Often these figures are portrayed as a passive decision that individuals make due to apathy, rather than an active one that is made due to genuine concerns about the system itself (Wilson & Barton, 2011; Wilson, 2008). Experiences while in the hospital system have also been found to contribute to the desire to seek early discharge, despite the negative health effects this may have (Wilson & Barton, 2011). Alongside these general challenges for Māori within the healthcare system, there are also more specified problems in terms of the experiences Māori have been found to have with staff.

Interactions with Staff and Services

The relationship between healthcare staff and indigenous people throughout the healthcare system and the hospital process is central to the perception of these hospitalisation experiences (Mbuzi, Fulbrook & Jessup, 2017). The interactions between healthcare professionals and other staff is therefore vital for Māori in their interpretation of whether a hospitalisation and hospital transfer is positive or negative. Unfortunately, there is a growing body of literature that demonstrates these relationships are influenced by the prejudices and preconceived ideas that some staff have about Māori and staff do not understand or acknowledge the underlying cultural concepts of Māori worldviews (Cram, Smith & Johnstone, 2003; Wilson & Barton, 2011).

There are often problems for Māori accessing culturally appropriate health services which is fuelled by an undercurrent of racial prejudices held by staff members (Wilson & Barton, 2011). Experiences of prejudice and discrimination can be extremely distressing for Māori and can cause them to feel marginalised in an already foreign environment (Wilson & Barton, 2011; Mbuzi, Fulbrook & Jessup, 2017). These feelings of marginalisation are often considered by the majority to be secondary to effective and quality treatment, when in actuality they are crucial to Māori whānau and the healing process. Prejudices held by staff members lead to the to the condescending attitudes that Māori often report from staff members (Cram, Smith & Johnstone, 2003; Harris et al., 2006). These prejudiced attitudes are then reflected in the subtle actions of staff members often creating an environment that perpetuates discomfort and anxiety, which significantly contrasts with the way a valuable therapeutic setting should operate.

It is important that health professionals consider the wider context they are working within and how various factors are interwoven and truly do affect the health and wellbeing of Māori whānau (Cram, Smith & Johnstone, 2003). Health professionals are not only responsible for the clinical outcome of their patients. They also have a responsibility to reduce health inequities and ethically reflect on this in an ongoing manner (Garneau & Pepin, 2015). Within Aotearoa, these responsibilities are evidenced in the national and regional policies for Māori Health and the services that aim to provide for Māori in a way that prioritises their specific needs.

Overcoming these Challenges

Policies

Due to the overrepresentation of Māori within the healthcare system, and the historic reasons for this, it is an absolute necessity that the issues and barriers that Māori face are targeted in a demonstrable way. In Aotearoa, governmental policy outlines the way in which these issues are to be addressed. At the more regional level of the Waikato District Health Board (DHB), the policy pertains to the current Māori Health Policy effective between 1 May 2015 and 1 May 2018 (Waikato DHB, 2015). The Māori Health Policy provides the framework for the strategies that the Waikato DHB will implement over the three year period in order to work towards more equitable health outcomes in accordance with Te Tiriti o Waitangi. Within the Maori health policy lies key principles that determine the ways in which Māori health services should be prioritised, delivered and later measured and evaluated. Notably, the Māori Health Policy is also applicable to external services that interact with the

Waikato DHB. All associated services are accountable to this policy document. (Waikato DHB, 2015).

The policy makes several key points on how these health inequalities will be reduced. According to the policy, audits will be carried out to ensure there is appropriate and sufficient resources allocated towards this priority area, services will be culturally appropriate and of a high quality. The Health Equity Assessment Tool (HEAT) will be used to adjust the perspective of the sector, and several narrower aspects of services will be identified, assessed and resolved. Included in these are the differences in access and quality of healthcare, the ways in which social determinants of health are unequally distributed and the undertones of discrimination that advantages certain populations of people over others. Within the policy, it is lastly stated that Māori specific positions be managed by Te Puna Oranga Māori Health services (Waikato DHB, 2015).

The Waikato DHB also works alongside local iwi in a governance partnership and have had an established Iwi Māori Council since 2000 (Waikato DHB, 2017a.). This Council recently signed a Memorandum of Understanding for Māori Health in September 2017 that is said to be leading the way for comprehensive change in the way health and disability services are delivered for Māori by aligning with the principles of partnership, participation and protection (Waikato DHB, 2017a.). Though these principles are outlined as crucial to deliverance of these health and disability services, there is little clarity with regard to the actual praxis at the forefront of these objectives. It is difficult to ascertain the ways in which these principles are being authentically implemented.

While these overarching policies may include well-needed, admirable goals, that does not mean to say that they are without fault, or that they are always reached. Previous research with Māori indicates that while these strategies may be in place, that does not mean to say that they are effectively implemented, as is demonstrated by the persistent gap in health outcomes and narratives of discontent with the system itself (Wilson, 2008; Wilson & Barton, 2012; Cram, Smith & Johnstone, 2003; Davis et al., 2006).

Available Services

The guidelines in the above policies are said to be executed through the implementation of various services that are designed to reduce and eliminate Māori health inequities. Within the Waikato Hospital whānau have access to a *kaitiaki* (guardian), and *kaitakawaenga* (mediator) for mental health services users (Waikato District Health Board, 2017b.). These are both managed by Te Puna Oranga Māori Health Services however as outlined on their official website, these are said to be accessible on request by speaking with ward staff or ringing a team leader (Waikato

District Health Board, 2017b.). This is a rather obscure way of facilitating access to these services as it is confounded by the reluctance of Māori to seek help when they may need it and does not seem to consider the *whakamaa* (shame, embarrassment) many Māori feel in a situation where there is such a considerable power dynamic and history of conflict between Māori and Western systems (Cram, Smith & Johnstone, 2003; Consedine & Consedine, 2003).

Chapter 2: Methodology

The present research involved the analysis of 22 interviews with Māori who had experienced a transfer to Waikato Hospital, either as a patient or as whānau support, in the 12 months prior to recruitment. Prior to this study, reflective research practice within the overall Hospital Transfers project reoriented the permissible scope for participants. Initially, both patients and whānau support had to be Māori to be included in the study but upon reflection this was adjusted to accommodate for the broadening notions of modern Māori whānau (Lawson-Te Aho, 2010). This alteration was a pragmatic recognition of the underlying Kaupapa Māori approach of the overall project.

These interviews were conducted by three researchers in 2016/2017. Following these interviews, they were transcribed and initial, surface level analysis was completed. This study was focused on analysing the content relevant to the interactions Māori whānau had with staff and services throughout the hospital transfer process.

Epistemology

This study utilised qualitative approaches within a Kaupapa Māori framework. This involved prescribing to a Kaupapa Māori conceptualisation of knowledge and values. Kaupapa Māori research emphasises the importance of self-determination and therefore this research draws on the realities of Māori whānau and includes a design that is by Māori, for Māori and with Māori (Bishop, 1999; Smith, 2012). It was important that these values and epistemological understandings were upheld throughout the process of this research so that the research could be purposefully and unapologetically distanced from the hegemonic lens that has historically been used with Māori and other indigenous populations (Smith, 2012).

Data Analysis

This research utilised a qualitative approach. This qualitative approach was chosen because it seeks to describe social realities and processes, and gives adequate attention to the meaning of people’s experiences (Flick, von Kardoff & Steinke, 2004). Qualitative research provides ‘thick’ descriptions that are a gateway to more insightful understandings of the realities that are described (Flick, von Kardoff & Steinke, 2004). Qualitative approaches also allow the complexities and nuances of different experiences to be captured and represented in a systematic way (Willig & Stainton Rogers, 2017). Accurate and in-depth representations of whānau experiences were crucial in this research, particularly alongside the importance of self-determination as a Kaupapa Māori principle as outlined above.

Analysis of the 22 transcripts was conducted within an interpretive phenomological analysis (IPA) framework. While IPA is usually conducted with a smaller sample size, this approach was justifiable as the transcripts were analysed with a narrower approach than usual and only particular content pertaining to staff and services was examined. The rest of the interview content was beyond the scope of the present research but is explored elsewhere by other researchers.

IPA is concerned with examining the way people make sense of their lived experiences (Eatough & Smith, 2017; Pietkiewicz & Smith, 2014). Within phenomenology, the perceptions and understandings of experiences are necessary components of research because of the authenticity and insight that they provide (Pietkiewicz & Smith, 2014).

IPA also relies upon an idiographic theoretical orientation. That is, IPA requires that individual cases be examined within their own unique contexts before they are compared and contrasted for various themes (Pietkiewicz & Smith, 2014). In aligning with this approach, the 22 whānau interview transcripts were all read on a case-by-case basis and information concerned with staff and service interactions was extracted appropriately. Across the individual cases, common emergent themes were identified to form a composite of these analyses. While these emergent themes were identified across the collective interviews, they were spoken to and exemplified by individual narratives. By doing so, the reader is able to assess the relevance of the analysis themselves, and more importantly, the voices of whānau are actively retained (Pietkiewicz & Smith, 2014). These themes were then discussed alongside the literature and appropriate policy documents in order to create a wider understanding of the experiences of Māori whānau and the way these experiences orientate themselves amongst previous research.

Chapter 3: Findings

There was a lot of variability in the perceived quality of care and support received by the Māori whānau who were interviewed as part of the hospital transfers project that encompasses this smaller study. While some whānau identified largely positive experiences with staff and services, most encountered multiple difficulties and obstacles that hindered the healing equation and added to the discomfort and stress of an already demanding and painful experience.

There was a prevailing climate of discontent throughout the experiences of these Māori whānau which was reflected in the four emergent themes as part of the analysis process. There was a lack of cultural competency of staff which was potentially underpinned by negative stereotypes and assumptions about Māori that were seen to influence care. Alongside these two themes there was also a lack of information dissemination from staff, compounded by additional barriers to effective communication between staff and whānau.

Lack of Cultural Competency

Cultural competency is vital when providing healthcare services for Māori and other minority groups (McNeill et al., 2010). Cultural competency encourages practitioners and staff to be conscious of their own culture, practices and beliefs, and how these may impact upon their interactions with patients of different demographics (McNeill et al., 2010). Across the interviews, it became apparent that these cultural competency needs were being inconsistently met by hospital staff despite the Waikato DHB outlining the provision of culturally appropriate services within its current Māori Health policy (Waikato DHB, 2015).

Throughout the interviews there were a small number of participants who acknowledged the cultural services at Waikato Hospital in a favourable manner. For most whānau however, experiences had a more negative skew. Several whānau spoke negatively of the cultural safety and competencies with sweeping general statements with one stating, “they have no culturally responsive way of working with our Māori whānau.” Since cultural competency centres on the patients’ experiences (McKinney, 2006), comments such as the above would suggest Waikato Hospital is failing many of its service-users in this regard. Another whānau pointed to a sense of Māori tokenism within the hospital indicating an approach that appears disingenuous to those that it should be benefiting.

Though it is not necessarily expected that staff completely immerse themselves within indigenous cultures to achieve the cultural safety and competency required to effectively work with Māori and other indigenous groups, it is expected that staff engage in critical reflection and cultural humility to facilitate an authentic patient-led partnership (Tervalon & Murray-Garcia, 1998). Within the hospital setting, this reflection and humility will often involve learning as much as one can about a Māori worldviews and referring patients and Māori whānau on to more knowledgeable cultural services. However, as mentioned earlier, there are distinct barriers to materialising this due to the lack of services that are proactively offered by staff. Alternatively, cultural services seemingly wandered the wards looking for Māori patients and whānau who may need assistance in their hospitalisation process. This approach is fairly haphazard and has led to Māori feeling as though they are not present in a great enough capacity with one whānau member stating, “You’re very lucky if they actually come to see you. Because maybe they’re too busy.” Cultural services are necessary for many whānau to feel comfortable in this largely foreign environment, so it is vital that they are readily accessible *kanohi ki te kanohi* (face to face) when whānau need them.

Negative Stereotypes & Assumptions

While cultural competency pertains to the cultural self-awareness of staff, cultural safety requires that marginalised groups feel free from adversity and prejudice at the hands of those same staff and services (Broom et al., 2007; McNeill et al., 2010). Staff-held negative stereotypes and assumptions about Māori were coupled with the lack of cultural competency mentioned. Preconceived ideas about Māori permeated through the various interactions that Māori whānau had with hospital staff. These preconceived ideas about Māori were considered a determinant in the quality of care received.

Assumptions about Māori were emphasised and highlighted concisely in a whānau interview where one of the participants commented on their experience with Waikato Hospital staff stating, “here go the Pākehā again, thinking all Māori are dumb.” Another participant stated, about a Māori patient they were supporting, “they have boxed him as a dumb, lazy, useless Māori man.” One whānau explains their experiences further by stating, “and it is just really frustrating, those assumptions, especially when you come into contact with real ignorant racist people who aren’t really there to give quality care. It is a transaction.” These statements speak directly to an issue that has been underscored in previous research wherein it has been found that patronising and paternalistic attitudes, likely influenced by similar negative perceptions, were held by healthcare staff members in Aotearoa (Cram, Smith & Johnstone, 2003).

Several whānau were adamant in the insight they provided about these experiences, often citing not only staff-held negative stereotypes and assumptions about Māori but also preferential treatment for Pākehā. One whānau was confronted with a major dispute within the hospital between the Pākehā side of their family and the Māori side. They described the situation and staff as “always leaning towards [the Pākehā side].” Another whānau commented on the way they believed a Pākehā man received access to an ambulance for his hospital transfer while they did not, based on his ethnicity alone. Whether this was the actual reason for this Pākehā individual’s preferential treatment or not remains unknown, though the perspectives of these whānau remain paramount as it is these perspectives that determine how the hospital transfer process is interpreted. From the realities described, not only do Māori feel as though they are being treated in a discriminatory manner, through negative stereotypes and assumptions, they also perceive their treatment as subservient, when directly compared with the majority Pākehā group. The self-reported way in which Māori are positioned as inferior to their counterparts has been shown to have a direct effect on health outcomes, which makes it an even greater cause for concern given the vulnerable position these whānau are already in (Harris et al., 2006).

While staff held these negative stereotypes, they were also met with reactionary suspicion and mistrust from Māori. Since the time of colonisation, Māori have had a tentative relationship with the Crown and governmental systems (Consedine & Consedine, 2011). As such, many Māori are understandably wary of the ways in which governmental and Western institutions have treated them in the past and this has left a legacy of hurt coupled with inevitable suspicion and mistrust (Wilson & Barton, 2012). This legacy of ill-treatment is clearly visible within the experiences of these whānau.

One whānau stated a personal injustice wherein they felt that they could not trust the hospital to take care of their whānau member due to negative interactions that they have had within their whānau in the past. The participant states, “so that is partly why we wanted to be around, because we think they didn’t treat my mum well. Her integrity, her dignity and all of that.” So while this participant was completely engaged in the healing process throughout the hospitalisation and hospital transfer, at least part of this presence came from a perceived necessity to play a protective role in a mistrustful environment. There were also concerns held by this whānau about whether or not their stay will influence the way staff interact with her whānau in future. The participant states, “I am just hoping myself and my family won’t be targeted in the near future for anything that will eventually come up, like any of my whānau members going to the hospital.” Often accredited to the Māori concept of whakamaa, (Cram, Smith & Johnstone, 2003), it may be that Māori are not too embarrassed to come forward with complaints, but too fearful.

Lack of Information Dissemination

The absence of information sharing between staff and whānau was strikingly apparent throughout the interviews. Information about the hospital, procedures and services was not readily disseminated. Even when the hospitalisation process was otherwise positive, a lack of information remained a persistent concern for most whānau.

Lack of information sharing is highlighted effectively in the following extract from one of the whānau interviews, "… every time I've been to hospital they have been awesome. But if like, if you don't know what you are entitled to up there they won't tell you." Evidence of this statement can be found on the Waikato Hospital official website where it states that "patients and their whānau can be put in touch with Kaitiaki by asking ward staff to refer them, or by ringing the team leader," (Waikato District Health Board, 2017b.). It is not until a patient searches for services and information that they are likely to receive it.

The pervasive nature of elusive and absent information from staff is exacerbated within the following statements wherein a whānau member articulates her understanding of the apparently non-existent services that in reality are actually present at Waikato Hospital, "they don't have any accommodation things or transport things, aye." Despite Waikato Hospital contracting rural buses for patients from Te Kuiti and several other districts and having a Whānau Whare available, patients and support people remain unaware of these provisions before, during and even after their hospital transfer process is complete.

Another related commonality between whānau was that even if they did acquire further information and knowledge of services, it did not always come from the healthcare workers or administration staff at the hospital. Sometimes this knowledge was acquired through second-hand sources or through serendipitous findings of brochures and flyers in the hospital waiting rooms. Within one of the whānau interviews a support person stated that they "were very much aware that there were whānau accommodations there somewhere…" but they were not offered access and did not receive any information about eligibility from the staff themselves. The absence of this information regarding accommodation services was subsequently described as "traumatic," and illustrates the distress of this particular whānau. Information being found from other sources is also evidenced in the following statement from another whānau interview.

> Interviewer: "Did you know if you were entitled to anything? Like did anyone else tell you that?"
>
> Interviewee: "No, I just happened to speak to my sister who lives up there and she just said to speak to them about a parking ticket, because I was going in and out of the carpark and there was a ticket we could get from them for $7 and it covered us for 7 days."

From these extracts about these whānau experiences it is strikingly obvious that these whānau were left completely unaware of their entitlements, and services that could have really aided them at such a strained time in their lives.

In another instance, one whānau were left without knowledge of their rights as patients within the public healthcare system. The lack of information dissemination is expressed in the following quote:

> "I said I'd like to look around for some papers, some consumers there –my rights...Oh we haven't got any. I said, you should have! All hospitals! They are all hanging up on the wall somewhere. And they said, what are you talking about? You know what I'm talking about, consumer's rights. Oh, hang on. And they were. And she came back –is this the pamphlet you are looking for?"

This whānau felt so alienated, attacked and gravely concerned about their treatment that they felt compelled to seek out the consumer rights guidelines from the staff nearby. Although they were proactive in the search for this documentation, it should not have been necessary for them to pursue this information themselves, especially when they were already going through a distressing situation otherwise. The burden of knowledge acquisition should not rest on the patient or whānau, especially during more distressing times. Without clear sharing of information, building rapport becomes difficult and the satisfaction of patients begins to suffer, as it has here (Bramhall, 2014)

The absence or lack of information sharing was compounded by the issues that were encountered by whānau in actually communicating with the healthcare staff and services. Not only were whānau left out of the information and knowledge sharing process, the fraction of information that they did receive was offered in a way that was not easily understandable or transparent for Māori whānau.

Barriers to Effective Communication

Access to information within the health sector is limited not only by what is offered, but also by the form that this knowledge takes. As Sir Muir Gray, Director of the United Kingdom National Health Service once put it, "in the same way that people need clean, clear water, they have a right to clean, clear knowledge." The parallel used captures the necessity for health knowledge and ancillary information to be reliably accessible. The whānau in the present study described experiences that were quite the opposite, where communication and meaningful dialogue between patients and healthcare professionals was instead strained and trying. The difficulties in communication between staff and whānau were due to a discrepancy in the language used by staff and patients. These barriers were due not only to a mismatch in preferences for Te Reo and English between some whānau and staff members respectively, but also because of the esoteric jargon that healthcare professionals had a tendency to use.

Some of the patients were more comfortable speaking Te Reo than English as they were often first language learners of Te Reo. However, this was in stark contrast to the staff who were all English speaking. In situations where patients were more comfortable speaking Te Reo, whānau support people often stepped in to translate between English and Te Reo and acted as intermediaries in this communication process. These communication issues create a state of confusion for the whānau and exacerbate the complexity of the hospital systems themselves (Wilson & Barton, 2012). Furthermore, in order for genuine cultural competency to be achieved within the health sector, it is widely acknowledged that language barriers and differences need to be addressed in an effective manner (Gray & Hardt, 2017). As consumers, patients have the right to access to a competent interpreter (Health and Disability Commissioner, 1996). While Waikato Hospital has staff that can act as interpreters, they are not readily offered as identified by these whānau, leaving thesnew whānau in a position where they must fill this role or suffer any consequences.

A second key communication problem was also identified within the whānau interviews as many felt that there was a disconnect between the highly technical and specialised way in which doctors and whānau would communicate. One whānau expressed this succinctly by stating that it would have been helpful if information was given with more clarity, and if doctors spoke to you “like a person and not a medical book.” Another whānau stated, “[the doctors] would just use all the big words, like I don’t understand it and I’ll tell them I don’t understand it. They would pretty much leave and the nurse would come in and simplify it.” Another whānau also spoke of their father’s experience in hospital stating, “he was really anxious about not fully understanding. My Dad is not dumb. Dad has a masters. But it was just the health speak and the way in which they deliver things.” The extensive use of complicated language on the part of healthcare professionals further distanced these Māori whānau from these staff on a personal level, hindering the creation of rapport in turn affecting perceived quality of care (Wilson & Barton, 2012).

Collectively, a lack of information and communication issues between Māori and staff also deprived Māori of the right to be true collaborative partners within their hospital transfer experiences and throughout the healing process. Despite the policy documentation that states Waikato Hospital’s commitment to partnership, participation and active protection when responding to Māori health issues, these information and communication issues greatly hindered these objectives (Waikato District Health Board, 2015).

Chapter 4: Recommendations

Recommendations have been formulated from the analyses of the 22 interviews that were explored within this study. The recommendations include compulsory ongoing cultural competency training for all staff, evaluation of cultural competency and cultural safety by Māori, for Māori and with Māori, and staff should be more proactive in offering services and other relevant information.

Compulsory Ongoing Cultural Competency Training

Many whānau who were spoken to as part of this research were disillusioned by the prejudices and lack of cultural competency of various staff. Racism and discrimination are human rights issues and are entirely unacceptable. It should therefore be compulsory for all staff to participate in iwi-led wānanga to improve on their cross-cultural skills. From a national perspective, this should be implemented in policy to ensure it is carried out at the regional level.

With reference to Waikato Hospital it would be beneficial if this initiative was developed and held in conjunction with Waikato Hospital’s Iwi Māori Council to align with the partnership, participation and protection principles within the revised Memorandum of Understanding. Wānanga for *all* staff would have a profound effect on the ethos of the hospital and would create a culturally conscious and respectful environment, and consequentially improve the health of Māori consumers.

The Evaluation of Cultural Competency by Māori, for Māori, with Māori

Māori whānau should not have to engage in major research projects in order to feel comfortable enough to voice the issues they have faced within Waikato Hospital or the healthcare system in general. It appears that cultural competency is customarily assessed from within the system rather than by Māori who actually navigate through the hospital and its services. Evaluating cultural competency in this way is exceedingly problematic as this power differential relinquishes the voice of Māori to colonial, Western influence and strips a sense of *tino rangatiratanga* (sovereignty) from those individuals and whānau who are most affected. Māori patients and whānau should be integral within the process of cultural competency assessment as they are the ones who utilise these cultural services. Unfortunately, it has been a long and arduous path for Māori to claim back the aforementioned spaces, and the fact that the power to exert change still remains outside of their hands in such a crucial way is truly disappointing.

Therefore, cultural competency of staff should be evaluated by Māori service-users. Whānau should be engaged with, on a more routine basis about their experiences. Speaking with these whānau is likely to be a tense space and it is unlikely that it would facilitate genuine discussion if this is conducted by the DHB itself. It would be beneficial if there were an external Māori stakeholder that could carry out these types of roles in order to reduce these unpleasant feelings and fear of reprisal, and promote candid responses. Within the interviews one whānau compared their experience at Waikato Hospital with a more favourable and engaging whānau-centred experience at Whakatane Hospital:

"I had received a Facebook message or something saying, we understand you have experienced services at Whakatane Hospital, would you like to complete a survey on the care. It is important for family to be involved in cares, so can you please complete this short survey. So I did that and I submitted it. So to come from that type of experience where they wanted to know how we felt and wanted our feedback, to that...it just seemed real..."

This whānau member described follow-up from the hospital as "real" indicating that genuine, forward approaches may also have the secondary effect of relieving feelings of Māori tokenism that was identified through the analysis.

Proactive Dissemination of Information and Services

Too often Māori have been positioned in a way that reinforces colonial power imbalances and therefore often feel reluctant to ask questions or ask for help, for fear of retribution as outlined by the narratives of these whānau. As such it is imperative that information is forthcoming from the side of the Waikato DHB and hospital staff to relieve some of these long-standing pressures on Māori.

Information and services were not offered in a proactive manner by staff. In order to ameliorate the lack of information sharing there should be a standardised way in which whānau are notified of different services (cultural support, interpreters, Whānau Whare etc) that they may be eligible to access. This information should be disseminated in an easily accessible way as part of a brochure or small information pack. Crucial information should be reinforced by doctors, nurses and particularly administrative staff in a gentle and straight-forward manner. It is important that this happens in an authentically helpful way and not in a condescending manner that will only solidify mistrust of the hospital system.

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Appendix 1

Final Reflections

Coming into this internship was a fairly nerve-wracking experience for me. I had not worked on an internship in the past and I was quite apprehensive about it. I felt as though I was stumbling through unfamiliar territory, and I wasn’t confident in my ability to navigate any of it. Over time these feelings dissipated and I became incrementally more self-assured in the content of my work, and in the context of it.

The first few weeks included various hui to meet the other Nga Pae o te Maramatanga interns and project researchers. This facilitated engagement and whanaungatanga between us all. In this stage of the research process, my supervisor was waiting on ethics amendments to be returned so that I could be given access to the anonymised whānau transcripts. During this preliminary period, I also began reading background literature in order to contextualise the research and gain a deeper understanding of the topic so that I could do justice to the stories that whānau entrusted us with.

In the first few weeks, all of the interns prepared slideshows and presented their respective internship projects at the Māori and Psychology Research Unit (MPRU) symposium. I was extremely tentative to present within this foreign research space but I managed it alongside the others. It was beneficial to have this experience, especially because the dissemination of information and research is so important within Kaupapa Māori frameworks and methodologies. I feel as though this presentation forum enabled me to see the deeper values in this work, and prompted me to reflect on how this study and future endeavours could be given back to the relevant Māori whānau, communities and researchers involved. This experience also made me realise the significance of knowing how and when to distance oneself from certain esoteric, in favour of more accessible ways of sharing knowledge.

Once ethics was approved, I began my first read through of the transcripts. This took longer than I anticipated, because the interviews were definitely content-heavy in terms of staff interactions and this took some time to process. Following this, I began the composite analyses of the individual cases. This was a slow and steady exercise and it was often difficult to recognise the boundaries of my specific research topic. It was easy to drift into various other facets that were brought up by whānau, so it was important to constantly consider the boundaries of my specific topic to ensure I didn’t encroach upon the work of Kahu and Bailey, the two other Hospital Transfers interns.

I found the writing up of the report to be quite straining. It was rewarding to see the narratives of whānau coming through in the research and writing process, but it also created an additional pressure to ensure I was painting an accurate picture for these whānau. I did not want to misrepresent anyone in my work and this worried me throughout a lot of this process. I was reassured by the hours I put into the work and the time I spent trying to engage with the transcripts. Despite the stresses I had in the writing, it was certainly helpful to have both Bridgette and Juliana available to read drafts where necessary and to receive feedback on the writing itself. It felt like a laborious job at the time but I was thrilled once I started making completing the various sections, and my confidence started compounding.

Overall, I felt like I made huge strides throughout this internship, not only in a research capacity but also in a personal capacity. There are parts of my identity that conflict with one another, and this became increasingly apparent throughout this internship. I am Māori and absolutely no one is permitted to quantify my identity or tell me otherwise, though this type of unapologetic indigeneity has not always been easy to hold onto, particularly when lacking the reo and specifics about my whakapapa. Through this internship, I have become more driven to take the initial steps in these journeys, trying to find a Te Reo course to enrol in with another of the Nga Pae interns, and speaking to both sides of my whānau about our whakapapa and accompanying narratives. These steps were undoubtedly encouraged by the content of this work, and the networks of people I have met along the way. For me, have the newfound courage to take these steps is a major personal victory, stemming directly from this summer internship.