



Tauwi general practitioners' talk about Maori health: interpretative repertoires

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Abstract

Aim This paper reports findings from a qualitative research project investigating how Tauwi general practitioners talk about Maori health. 'Tauwi' is a Maori term for non-Maori New Zealanders.

Methods The transcripts of interviews with 25 general practitioners from urban Auckland on the topic of Maori health, were subjected to detailed discourse analysis. Through these readings, interpretative repertoires (patterns of language use on particular topics) that participants drew upon in their interviews, were described.

Results We outline the main interpretative repertoires utilised by participants in their talk about Maori health. These include key explanatory forms relating to prevalence and causality of Maori health problems, and rationales for specialised practices when working with Maori.

Conclusions The repertoires, which are considered to be generalised discursive resources for the construction and elaboration of specific arguments, are oriented to constructions of Maori health that either blame Maori for their plight or justify existing service provision. As such, they are antithetical to arguments for changes to policy and practice that might bring about population-level health gains for Maori.

Our project, investigating the talk of Auckland general practitioners and Maori users of general practitioners' services about Maori health, is part of the "discursive turn" in social science^{1,2} toward qualitative, language-oriented investigations of trenchant social issues. Underpinning this work is the growing understanding of the role of talk in negotiating, confirming and challenging social realities.^{3,4} Diverse methodologies, referred to as "critical discursive" approaches,⁵ for investigating effects of talk in social life, including medical practice,⁶⁻⁸ are now well developed.⁹ One of these approaches, discourse analysis, the primary tool for this research, has been described in detail by various authors¹⁰⁻¹² and outlined in action in the current project by McCreanor and Nairn.¹³

Using such approaches, we were interested to see if patterns would emerge in talk on the topic of Maori health generated as part of relatively free and unstructured interviews with our participants. We went into the interviews with some general topics – health disparities, historical contexts, traditional Maori health practices, gender issues – but deployed these mainly as starting points. The aim was to have doctors speak freely and, as much as possible, formulate the issues in their own terms. In the current paper, we present a sketch of the research project and an overview of common patterns of talk in the database we gathered.

We wish to stress that we are not interested in personalising the findings that we report, preferring to regard the data and the analyses that flow from them as reflecting

and constructing a particular niche within a broader environment of cultural relations. Far from feeling that our participants were wanting in sensitivity or humanity, we know them by reputation and through our interactions with them to be concerned, caring people who are, both in the interviews and in their profession, aiming to enhance and improve the lives of all the people with whom they work.

Methods

The database consists of the transcripts (and audiotapes) of interviews with 25 female and male Tauwi general practitioners working in Auckland; some 501 pages of text. We used discourse analysis,^{3,9} which is based upon multiple, detailed readings of the database, to develop a systematic and comprehensive description of the ways in which language was deployed to establish and defend specific arguments or positions within the general topic. Verbatim texts or sections of text that use recurrent themes (at first rather loosely defined) were collated into files. Patterns of lexicon, syntax, grammar and semantics – known as interpretative repertoires in discourse analysis – within each file were clarified by further intensive reading, allowing the researcher to describe and illustrate the content and function of these common elements. Our recent publication¹³ details the application of this method to the current database and a paper published in this journal in 1996² is also valuable in explaining some of the methodological issues.

Results

The following are outlines of the repertoires that we read from the data. These sketches are summaries of more lengthy analyses, consisting of detailed descriptions of themes illustrated by verbatim excerpts from transcript. They are derived from the files of data sorted by repertoire as described above. Each is worthy of considerable elaboration and further analysis; for example the first repertoire reported here is the subject of an entire paper recently published elsewhere.¹³

Maori morbidity Most participants agreed that their experience of Maori health was congruent with the position indicated by nationally collated data for Maori, and on this basis that Maori health is in crisis. Maori were seen more commonly and were more severely afflicted by serious and mundane conditions. While some participants argued that Maori under their care were much better off than Maori in general, most concurred with the view that there was a real problem nationwide.

Most participants' explanations of the differential between the health of Maori and that of the rest of the population turned upon interactions between genetics and environment (primarily socioeconomic status and culture) in a conventional medical analysis. A minority argued that there is no significant difference between Maori and Tauwi health and justified their claim especially by reference to uncertainties over Maori identity and the confounding effects of socioeconomic status. Both sets of arguments focus on the constitution and behaviour of Maori people and thus minimise the significance of the historical and political context of Maori health.

Maori identity Maori identity was very often seen as deeply problematic, and was defined by different parameters in different settings. Scientific definitions based in genetics were routinely offered, but regularly conflicted with social constructions of Maori identity. Most participants assumed that genetic mixing through intermarriage meant that there was no objective standard. Identity was socially determined, and dependent upon diverse criteria such as self-identity, appearance, lifestyle and world-view. In practical terms, this ambiguity was often manifest in doctors simply not knowing whether their patients were Maori or not, and there were some participants who reported instances in which the patients themselves either did not know or could

not decide upon a fixed identity. Some participants thus argued that there was insufficient justification for doctors to practise differently with Maori and Tauwiwi patients.

Compliance Participants widely reported that one of the key issues in working with Maori was non-compliance. Compared with the rest of the practice population, Maori do not do the right things in relation to their health. In terms of a standard medical definition of compliance, they do not take their medication, do not follow prescribed regimes of treatment, do not arrange for repeat courses of medication, do not attend to follow up. A complex of social or organisational factors was seen as surrounding non-compliance, and exacerbating or contributing to it. Maori present late, and do not attend regularly or sufficiently frequently. They have diffuse lines of personal responsibility, which means for example that you cannot be sure who is a child's caregiver, or that whanau members may present instead of the actual patient. They do not know their personal medical history, they do not know what medications they have taken or what the medications they take are for. They have different attitudes and expectations about health, based in a present-focussed, laissez faire world-view. They do not embrace preventive medicine and they expect a quick-fix solution in a crisis. Maori men almost never come to the doctor.

Doctors did their best for Maori, but unless patients complied with the treatment they could not reasonably expect to achieve results. Explanations of the non-compliance phenomenon were diverse, and ranged from those cast in terms of ignorance and poverty, to attributions of wilfulness and self-destructiveness. Accounts of Maori compliance included ascribing it to assimilation, wealth and/or education, and to a positive Maori identity. A small proportion of participants could point to some groups of Maori (eg, the ones in their own practice) with whom they experienced no problems of compliance. In some instances, this led to the splitting of Maori into compliant and non-compliant groups.

Style of working with Maori A small number of participants held strongly to the position that there was no difference between working with Maori and non-Maori patients. This stance drew upon the ideas about Maori identity canvassed above and on an egalitarian discourse, which suggested that this was a just, non-discriminatory way of doing things.

More commonly, participants reported important differences in the ways in which they would work with Maori and Tauwiwi patients. At a pragmatic level, participants noted the need for allow more time with Maori patients to facilitate the building of rapport and to allow for a more flexible unfolding of the medical history. A key element was the presentation of information as clearly and simply as possible, with the use of pictures and repetition favoured. The observation was frequently made that work with Maori patients often involved group consultations with different lines of communication and responsibility (especially via the senior women). Consultations were felt to necessarily focus on the individual in context and avoid an abstract 'disease-on-legs' approach. In general, there was a feeling that extra effort was needed on the part of the doctor to achieve equitable outcomes for Maori patients, especially concerning issues such as follow up and preventive medicine. Flexibility over punctuality and payment was also commended.

Some participants with knowledge of Maori culture spoke of protocols for touching or examining patients, and of appropriate ways of asking permission, explaining treatments or conditions. The call was for greater cultural sensitivity on issues specific to Maori, with appropriate use of reo, kaumatua, ritual and protocol.

Maori conceptions of health Many participants were clear that Maori thought about health in quite different ways than do Tauwi, but were able to give only a general outline of what Maori conceptions were. Very few had knowledge of formal Maori models of health such as Whare Tapa Wha¹⁴ and many resorted to listing practical manifestations of a supposed conceptual model. Participants interpreted their observations of Maori apathy, lack of motivation and lower prioritising of health issues as arising from symptomatic rather than preventive management of health. This approach was derived from a laissez faire world-view and a 'quick fix' approach to illness.

While most participants professed ignorance of traditional Maori health practices, they also declared that their basic approach would be one of tolerance, regarding rongoa (traditional Maori medicines) as either harmless or of limited efficacy. Participants named few actual remedies or practices from Maori traditions, and felt that acquiring such knowledge was not their responsibility or interest. A discourse about complementary medicine was drawn upon to argue that if there was no harm done in the course of such practices they were to be accepted and even encouraged. Most participants reported that they had not come across such practices in their work, but many had heard about them indirectly from patients and other sources.

Socioeconomic status Many participants reported that socioeconomic status was a key issue in Maori health and that Maori were mainly afflicted with diseases of poverty. Socioeconomic status was seen to have an impact via diet, accommodation, access to healthcare, low educational attainment, chaotic social organisation and related factors in a multifactorial way. To varying degrees, this interpretation confounded the image of a crisis in Maori health per se, and supported the de-emphasis of cultural factors.

Maori health initiatives Participants were ambivalent about Maori-driven initiatives in health. Conceptually, this stance was rooted in arguments for scientific hegemony and against any form of political or cultural dualism. In practical terms, there were reservations about both fiscal and ideological competition with the established services. However, some participants were clear that, provided Maori took the responsibility as well as the power and resources, Maori self-determination in health was a positive and possibly crucial development.

This talk often coincided with acknowledgement that established healthcare systems had failed Maori, with health disparities cited as prima facie evidence for the claim. The scope of the failure ranged from the ideological error of not ensuring Maori control of their own health institutions and practices, to the political interpretation that noted widespread and entrenched anti-Maori attitudes and practices within Tauwi institutions. Other concerns focussed specifically on various barriers to Maori use of services such as rigid and formal structures, unacceptable waiting lists, impersonal style, lack of cultural sensitivity and lack of understanding of Maori needs. Several participants recorded particular areas of concern, especially with Maori youth in the areas of drugs and unwanted pregnancy, and in general with diabetes.

History Few participants spontaneously raised accounts of the state of Maori health prior to the arrival of outsiders to Aotearoa. Of those who did talk about the history of Maori health, there was a split between those who believed Maori life in this era to be brutish and short and those who held the opinion that Maori health was probably exceptionally good. However, most expressed the opinion that the arrival of Europeans in the country spelt the beginning of the current crisis in Maori health. Disastrous changes were seen to have followed from the introduction of infectious diseases, weaponry, drugs and foodstuffs to which Maori were unaccustomed.

Gender While some participants saw no differences in style between Maori women and men, most reported that they either rarely saw Maori men or that when they did they were much harder to communicate with than the women. In contrasting Maori women and men, most participants reported that Maori men were much more difficult to communicate with and that Maori women were more open and trusting.

Multiculturalism Two complementary lines of argument emerged in the area of culture. Speakers argued against targeting services to Maori, as this represented a form of privilege¹⁵ that was unfair and unethical. The perceived ambiguity over Maori identity bolstered the idea that no distinction should be made between Maori and Tauwi on principle. However, some participants argued consciously against this latter position, advocating a bicultural stance that gave priority to the indigenous people and sought to deliver equal health outcomes through culturally appropriate services.

Discussion

The patterns of talk and argument sketched above represent interpretative repertoires that constitute a significant part of the discursive resources that can be drawn upon by Tauwi doctors in their work with Maori patients within general practice. We note that our findings may represent only part of the resources available and that in circumstances apart from the research interview different elements may appear and play crucial roles. We stress that the form in which these materials are presented is generalised and collated to the extent that no speaker would necessarily reproduce all or any of the elements in the manner that they are rendered here. However, it is the case that these patterns account for a very high proportion of our data and that there are no substantial ideas from the data set that are not represented here.

It is very difficult to see how to use these resources in ways that do not blame Maori for their own condition or variously justify established approaches that doctors take to their work with Maori. The 'Compliance' repertoire provides a powerful example of these features, combining as it does explanations which account for Maori ill-health in terms of Maori behaviour and culture, with the caveat that without compliance doctors cannot be held accountable for outcomes. The ambiguity entailed in the 'Maori identity' repertoire generated a tension with a central paradox of primary healthcare; all patients must be treated equally, that is, they must all be treated as individuals, yet all individuals are different! Individuality was privileged over cultural (or any other) aspect of identity, providing a rationale for the failure to address health issues that fall outside this focus.

More generally, these interpretative resources lend themselves to explanations of the poor health status of Maori as a function of being Maori and so naturalise or legitimise a situation that is ethically, socially, and economically unacceptable. The

dominance of such accounts means that alternative explanations of Maori health and morbidity are marginalised. These alternatives could, for example, emphasise the social and political impacts of colonialism, or of contemporary contexts and processes of health practice, on Maori health.

Key exceptions to this tendency arise from the 'Style' and 'Maori health initiatives' repertoires. In the former, participants were strongly articulating accounts of practices that they claimed made their work with Maori more effective. In the latter, minority affirmation of systemic failures in health services and the importance of Maori self-determination in health could help build positive alternatives.

If the repertoires we have described are widely used among general practitioners, they represent a cause of concern, as they may shape actual interactions between Maori patients and their Tauwiwi doctor. The impact of doctor-patient communication on health^{7,8} and links between discrimination and health¹⁶ are part of the research literature. Communication between doctor and patient is increasingly regarded as central to the practice of primary healthcare, directly and indirectly determining the outcome and therefore the efficacy of such enterprise.

We argue that our findings have serious implications for Maori health outcomes from primary care, for the education and training of primary healthcare workers and for the development of policies on Maori health.

We notice that our participants' explanations of the state of Maori health rarely relate to widely available Maori theories of health.^{17,18} These holistic, communitarian frameworks emphasise social, cultural and economic interconnection as the basis and context of individual health, so that such factors take a crucial role in the explication of Maori health status. Our interpretation of Maori theory is that particular historical, political processes and social contexts should be interrogated for their contributions to the established power relations within which the interactions and practices of primary healthcare are located. In the case of Aotearoa/New Zealand, such perspectives invite us especially to consider the colonial context of healthcare services in general.

The profound negative impact of 160 years of colonisation upon all aspects of Maori life¹⁹⁻²¹ and especially upon Maori health and wellbeing is clear. As well as diverse sources of introduced mortality and morbidity, Maori have experienced open warfare, land confiscation, destruction of their economic base, legislative injustice, social discrimination, and racism. These multiple assaults have resulted in severe disruption of diverse Maori cultural forms and institutions across the board. Maori have been effectively reduced to the status of second-class citizens in their own country, as reflected in the differential health statistics that are the subject of the participants' talk in this paper, and other indicators such as wealth, education and social status. In the context of Maori health, the marginalisation of the cultural infrastructure that once cohered around Maori healing and medical practices, amounts to damage that can only have compounded the more obvious losses.

We argue that the interpretative resources highlighted in this research and discursive practices that draw upon them, are problematic to the population-level improvement of Maori health. Such talk, when it identifies the causes of disparities in Maori health in characteristics of Maori or Maori social organisation, stands in direct contradiction of the findings and recommendations of Maori scholarship and thinking. This tension needs to be addressed if general practice is to optimise its potential contribution to

Maori health. What is needed is work in both theoretical and applied fields that addresses the contexts and processes within which Maori health is constituted, and enhances understanding of the role of general practice in these dynamics. Of critical importance to this effort will be the consideration of the paradigms within which doctors operate, and analyses of the power relations that underpin the everyday interactions of general practice.

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Acknowledgements: The work described in this article was supported by the Health Research Council of New Zealand, HRC grant 94/298. Special thanks to Drs S Crengle, N Turner, P Woolford and F Cram, who read and commented on drafts of this paper.

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References:

1. Harre R, Gillett G. The discursive mind. Thousand Oaks, CA: Sage Publications, 1994.
2. Ryan K, Denz-Penhey H. Qualitative research in medical practice. NZ Med J 1996;109:87–8.
3. Wetherell M, Potter J. Mapping the language of racism: discourse and the legitimization of exploitation. Hemel Hempstead: Harvester Wheatsheaf, 1992.
4. Fairclough N. Critical discourse analysis: the critical study of language. London: Longman, 1995.
5. Edley N. Analysing masculinity: interpretative repertoires, ideological dilemmas and subject positions. In: Wetherell M, Taylor S, Yates SJ, editors. Discourse as data: a guide for analysis. London: Sage Publications, 2001.
6. Radley A, Billig M. Accounts of health and illness: dilemmas and representations. Sociology of Health and Illness 1996;18:220–40.
7. Silverman D. Communication and medical practice. London: Sage Publications, 1988.
8. Simpson D, Buckman R, Stewart M, et al. Doctor-patient communication: the Toronto consensus statement. BMJ 1991;303:1385–7.
9. Wetherell M, Taylor S, Yates SJ editors. Discourse as data: A guide for analysis. London: Sage Publications, 2001.
10. Potter J, Wetherell MS. Discourse analysis and social psychology. London: Sage Publications, 1987.
11. McCreanor T. “Why strengthen the city wall when the enemy has poisoned the well?” An essay of anti-homosexual discourse in New Zealand. J Homosex 1996;31:75–105.
12. Taylor S. Locating and conducting discourse analytic research. In: Wetherell M, Taylor S, Yates SJ, editors. Discourse as data: a guide for analysis. London: Sage Publications, 2001.
13. McCreanor T, Nairn R. Tauiwi general practitioners’ explanations of Maori health: colonial relations in primary healthcare in Aotearoa/New Zealand? JHealth Psych 2002;7:509–18.
14. Durie M. Whaiora: Maori health development. Auckland: Oxford University Press, 1994.
15. Nairn R, McCreanor T. Race talk and common sense: patterns in Pakeha discourse on Maori/Pakeha relations in New Zealand. J Lang Soc Psych 1991;10:245–62.

16. Krieger N, Sidney S. Racial discrimination and blood pressure: the CARDIA Study of young black and white adults. *Am J Pub Health* 1996;86:1370–8.
17. Durie M. *Te pae mahutonga: a model for Maori health promotion*. Palmerston North: Te Putahi a Toi, 1997.
18. Pere R. *Te Wheke: Whaia te Marangatanga me te Aroha*. In: Middleton S, Jones A, editors. *Women in Aotearoa*. Auckland: Allen and Unwin, 1988.
19. Smith G. *The issue of research and Maori*. Auckland: Research Unit for Maori Education, 1992.
20. Smith LT. *Decolonising methodology*. Dunedin: Otago University Press, 1999.
21. Walker R. *Ka whawhai tonu matou*. Auckland: Penguin, 1990.