

Applying a Māori-centred consultation approach for engaging with Māori patients: an undergraduate medical student case study

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Introduction

For some years now the dominant text for teaching consultation skills has been 'patient-centred medicine'.¹ Although this method is used internationally, it was developed in Canada, with a strong cultural bias towards Western European patients, and its very title, as a method, is at odds with a traditional Māori way of viewing the world.² There are indications that, for Māori, inaccurate and inappropriate medical assessment can lead to misdiagnosis and mistreatment and thus can contribute to existing health inequalities in a number of areas.³ There is also evidence that, while most clinicians engage with patients with good intent, knowingly or unknowingly, they can contribute to negative patient experiences and ethnic/racial disparities in health.⁴ In order to prevent this and to ensure positive health experiences for Māori, it is vital to learn culturally appropriate and effective methods of engaging with Māori patients.⁵

As part of the curriculum at the University of Otago, Aotearoa/New Zealand, undergraduate medical students learn the Calgary–Cambridge guide to medical interviewing.⁶ As well as this, they combine their biomedical knowledge with Hauora Māori (Māori health) principles and apply these using a Māori patient long-case interview. The main focus of this long-case is to apply an holistic approach to interviewing Māori patients, based on the combination of the Hui Process (a

Māori communication and patient engagement process)⁵ and the Meihana Model (an holistic Māori model of health).³ The Hui Process provides a Māori-centred approach to history-taking, developed from the customary Māori practices that are observed at hui (meetings). This is initially taught during a marae-based (Māori meeting place), cultural immersion programme to fourth-year medical students, who learn a culturally competent way to interview Māori patients following a four-step process.⁷ During this immersion programme, these students are also taught the Meihana Model, a clinically focused Māori model of health, as a framework for history taking.³ This model was designed to synthesise clinical and cultural competencies, to better serve Māori within a clinical setting. Whānau (extended family) are identified at the centre of the interview, and this model challenges the student/practitioner to explicitly engage with the whānau as part of the interview and any subsequent treatment plan.

The following is a description of the practical application of these Hauora Māori principles in a clinical hospital setting, including excerpts from a case assignment written by a fourth-year student, after conducting an interview with a Māori patient.

The first step, the mihimihi (greeting), begins with the student introducing themselves, ex-

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Pounamu

MĀORI PRIMARY HEALTH CARE TREASURES
Pounamu (greenstone) is the most precious of stone to Māori.

'Ahakoa he iti, he pounamu'
(Although it is small, it is valuable)

plaining their role, confirming patient details, including ethnicity, stating the reason for the interview, and obtaining fully informed consent. Use of basic te reo (Māori language) is encouraged, as appropriate, during this step and throughout the interview. This use of te reo has been recognised as a contributing factor in building a trusted patient–doctor relationship.⁸

The second phase, the process of whakawhanaungatanga or the building of a relationship, follows the exchange of mihi mihi, and continues throughout the interview. Whakawhanaungatanga is a critical concept of demonstrated relevance to both culturally appropriate research,⁹ and clinical encounters with Māori patients.¹⁰ It is grounded in the key cultural principle of acknowledging the interconnectedness and interdependence of an individual, members of the whānau, immediate and extended family, community and wider society. In the clinical context, whakawhanaungatanga has a purposeful focus directed towards the health professional establishing a cultural connection with the patient, thus distinguishing it from basic rapport.¹¹ The process provides a holistic context that permits the student to place the information gathered within a cultural framework, ensuring a more accurate interpretation and understanding of the patient.¹² A vital part of this step is the student's sharing of appropriate stories and information, so as to balance the interview and avoid a one-sided interrogation scenario.

Excerpts from the student case study

The process of whakawhanaungatanga, or the building of the relationship, was initiated by the exchange of mihi, the sharing of our stories. This exchange took place before any thought was given to the 'information gathering' biomedical approach, oft practised in Western Medicine. We exchanged stories about where we'd come from: JT (the patient) talked of her childhood; being raised by her grandfather, and how she spoke te reo at home. Her iwi heritage gave an opportunity to create a common bond, as my wife has ancestry to the same iwi. Whakawhanaungatanga is an ongoing process and was maintained and reinforced throughout our kōrero (talk) through:

(1) an emphasis on seeing JT as a whole person, in contrast with the reductionist focus-on-the-medical-condition approach; and

(2) through reference back to the information shared in our mihi.

It was evident throughout our kōrero that a connection had been made and this was reinforced when, at the end of our two-and-a-half hours together, JT gave me her contact details and asked me to make sure that I keep in touch. We were not time-pressured and this allowed space for the conversation to go places that it likely would not have if I was the house surgeon admitting JT or the GP [general practitioner] seeing her in clinic. This raises the question of the adequacy of 15-minute GP appointments, or biomedically/tinana (physical health)–only focused consultations to facilitate conversation that has the ability to promote real consideration of one's health status and behaviours.

In the clinical context, whakawhanaungatanga has a purposeful focus directed towards the health professional establishing a cultural connection with the patient, thus distinguishing it from basic rapport

The third step of the Hui Process is the kaupapa—the main purpose/reason for the interview is largely dependent on the effectiveness of the first two steps. In order to be able to obtain in-depth information, it is important that the patient feels at ease and can trust the student/clinician with sharing their sensitive personal information. For many Māori, this information is viewed as a taonga (treasure) belonging not only to them as individuals but also intrinsically linked to their tīpuna (ancestors) with whom they remain connected to through the generations.

As we got to talking and I actually listened (as opposed to charging in with question after question), I began to discover a lovely and vibrant, but 'broken' lady. The interview progressed in a semi-structured kind of way, loosely following the pattern described above and that of the Meihana Model, where health is seen as encompassing six different

facets (tinana—physical health; whānau—the family aspect; hinengaro—mental health; wairua—spiritual health; taiao—the environmental aspect; and iwi katoa—the wider health system context).

Tinana (physical health)

JT was admitted to the respiratory ward, where she spent six days receiving treatment for pulmonary oedema. When visited by the respiratory nurse at her home (five days ago), she was found to be breathless, unable to complete full sentences, and ‘gasping for air’. An ambulance was called and she was taken to the emergency department for assessment. She had recently been discharged following a similar episode. An occasional unproductive cough and some pain associated with this was reported but otherwise nil of note. She had a number of comorbidities, including: congestive heart failure; ischaemic heart disease, with previous non-ST elevation myocardial infarction; chronic obstructive pulmonary disease; asthma; obesity hypoventilation syndrome; Type 2 diabetes (insulin dependent); paroxysmal atrial fibrillation; and osteoarthritis of both hips, for which she was awaiting total hip replacements. She regularly took multiple medications: insulin; salbutamol; fluticasone/salmeterol; simvastatin; metoprolol; quinapril; frusemide; and fluoxetine. She had been seeing a dietician and felt her diet was good, with plenty of fruit and vegetables. JT is an ex-smoker, with a 15 pack-year history.

Whānau (family/social supports)

JT is one of 16 children; she has four children of her own and eight mokopuna (grandchildren). Both her parents died early but she had little information to give about their health. JT lives at home with her partner who is also unwell, but has good support from her children who live close by. She has some home help. No whānau were present during our kōrero (talk) but she mentioned that they are quite worried about her health. JT discussed her iwi (tribe), hapū (sub-tribe), and marae (meeting house) affiliations, along with her maunga (mountain), the basis of her sense of connectedness. She has no marae involvement in Wellington but is involved with a number of kaumātua (elder) groups. JT is now retired but used to work as a social worker, and was involved with the policy board for a local health provider and a number of other groups.

Hinengaro (psychological/emotional)

Regarding her beliefs about medication and adherence, JT had an ‘I just do as I’m told’ attitude, and felt her control of diabetes was a good example of success. Enforced bed-rest has afforded JT the time to reflect and given the benefit of hindsight she sees herself as being mostly responsible for her poor health. This made her feel unhappy:

[The] truth hurts. [Expletive] does it ever!

An hour into our kōrero, I said to JT that it seemed as if she had come to a point of realisation and that she was starting to take ownership of her own health. This seemed to resonate with her, as she broke down in tears, agreeing that this was exactly how she felt and it had taken her a very long time to come to this realisation.

Wairua (spiritual/connectedness)

With reference to Wairua, JT’s comment was that she believes in a Māori model of health, by which she was referring to the Whare Tapa Whā model.¹³

A Catholic nun had visited her today to take her through a karakia (prayer/incantation), but in general she felt that she didn’t really take great care of her wairua, her spiritual health.

Taiao (environment)

JT and her partner live in a modified home on a flat section (her previous home had steps) with a wet shower area, a handle above the bed and a number of other modifications. Due to her immobility (both hip osteoarthritis and obesity-related), she uses a walking frame when outside the house. Some home help is currently provided and this is being reviewed with a view to increasing this service.

Iwi Katoa (health systems)

JT has her own GP and felt that she had easy and good access to health care, but thought this was likely related to her position as a social worker (previously) and her role with the local health provider. She said that she knew many Māori who don’t know where to go when they have health concerns, and therefore don’t seek help.

Māori cultural beliefs and values

JT describes Māori as ‘the same but different’, in that those from different iwi and hapū often have different beliefs about health. For example, talking about different aspects of health is tapu (sacred/restricted) for some and there can therefore be a reluctance to seek help. Māori are whakamā (embarrassed/shy) when talking about certain sensitive body parts. She said that she loves the cervical screening television advertisements for Pacific women (shown on New Zealand television) but wished there was something similar for Māori. JT felt it was important for the elders in the community to stand up and model good health practices to the younger generations—she said that she felt she hasn’t done a great job of doing this so far, but plans to change that.

Māori and non-Māori, to which she responded that she felt many Māori need to take responsibility for their own health. In addition, she added that non-Māori doctors need to learn how to talk with Māori patients so that they will be more likely to share information about themselves.

I asked explicitly if she had any questions for me and allowed space for her to consider her response. JT’s only question was to ask that I keep in touch, to which I promised to email and visit her again during her stay in hospital (which I did the following day). JT hoped that our meeting would be of use to me in my medical training and she offered this advice to me, as a doctor-in-training: ‘learn well, do well, be true to yourself’ and asked me to: ‘give back to Māori’.

Poroporoaki

The final step of the Hui Process, the Poroporoaki (closing or concluding the encounter) is an important part of the interview process. Evidence shows that, for Māori, this part of the consultation can be suboptimal and incomplete at times, and is an important part of a culturally appropriate and effective health literacy approach with patients.⁵

Case study: Poroporoaki

Poroporoaki is the process of farewell and conclusion of a meeting. It allows each party the opportunity to share their thoughts regarding the encounter and, in this context, ask questions and to negotiate future plans. Our kōrero drew to a close when JT again spoke of the sense that she felt responsible for her ill health. She believed that she had played a large part in her current poor health state, saying that she had neglected to take care of herself, and had deferred seeking help for health concerns. We talked of the opportunity she now had to take ownership of her health and she explained that her mokopuna were the motivation for this. She felt that our conversation had allowed her an opportunity to ‘get a load off her chest’ and that she hoped ‘people would see a change in her’.

I asked JT for her opinion on what the causes were for the discrepancies in health status between

Student reflections

JT’s comments (regarding taking more responsibility for their health) demonstrate a degree of internalised racism, where many Māori blame themselves to a greater or lesser extent for their poor health outcomes. While individual, whānau and community responsibility is undoubtedly important, this cannot occur in the absence of a high level of health literacy and good access to preventive and curative medicine, and while suffering under a disproportionate burden of socioeconomic and structural determinants of health. If accurate history taking is a priority for forming correct diagnosis and treatment of patients, then the lens must also fall on the responsibility of health professionals to follow JT’s advice and simply ‘learn how to talk with Māori patients’. Culturally validated tools, such as the Hui Process, along with Māori models of health, such as the Meihana Model, exist not only for student doctors but for all health professionals to utilise in order to reduce health disparities in Aotearoa/New Zealand.

My kōrero with JT was an enjoyable and rewarding experience. I felt privileged to be a conduit for JT to reflect on the state of her health and come to such a revelation, and ultimately play a small role in her healing process. Both the sessions on ‘Interviewing a Māori patient’ and ‘Calgary–Cambridge meets the Hui-Process’ at Ngātōkōwaru marae prepared me well for this interview and I was able to loosely follow the Meihana Model and the Hui Process

as a framework. Having utilised these tools now will help to give shape and structure to my future interactions with Māori patients.

Thought provoking episode report

Another aspect of the undergraduate medical programme at the University of Otago Wellington is the teaching of reflective practice. Students are asked to write a 'Thought Provoking Episode Report' (TPER), choosing an episode that provokes their thinking and analysis regarding the professional and ethical issues raised by the episode. The following is an excerpt submitted by the student while reflecting on his interview using the Hui Process and Meihana Model.

This was an eye-opening and thought-provoking experience. I was bemused and disappointed to discover that I'd become so cynical as to want to conduct an interview that took as little time as possible in order to move on to the next item on my list of things to do. This approach could not have fostered the kind of relationship that allowed time and space for openness, reflection and ultimately healing. Fortunately the Hui Process, Meihana Model, and a small measure of good sense, derailed our conversation from the path it would likely have taken. In the end, we were not time-pressured and this allowed space for the conversation to go places that it likely would not have if I was the house surgeon admitting JT, the GP seeing her in clinic, or indeed the medical student whose goal at the outset was taking as little time to glean as much information as possible. Taking the time to listen to our patients is a critically important skill. Indeed, it is likely the most important, and this has been hammered home to me by this experience. In the face of the busy medical student, house surgeon or GP life, I must not forget that taking the time to listen is a skill to be treasured and honed, and can yield great results.

It strikes me that doctors hold a privileged position in many people's lives: on occasion patients will share their most intimate thoughts and fears, and often we will be the only party privy to these. What a position of responsibility; what we do with this information is surely of great importance. We must deal with such matters sensitively and endeavour to offer encouragement and hope where

possible, although often to just lend an ear will be the best medicine.

I wonder if taking up JT's request to keep in touch via email was wise. As a general rule, I think that this is not a good practice to get into the habit of doing and flirts with the professional patient-doctor boundary. However, in this context, given JT's cultural background and the nature of our conversation, I felt it appropriate to send an email encouraging JT in her newfound desire to take ownership of her health.

I find one of the difficulties of history taking is having a hidden agenda—knowing I have to come back to the next 'tick-box' on my list of must-ask questions, instead of focusing on and really listening to the person in front of me. However, by the same token, without an agenda (specifically the Hui Process and Meihana Model in this instance), I may not have asked the questions that provoked such thought in JT and thus a different outcome may have resulted. Having used these tools now will help to give shape and structure to my future interactions with both Māori and non-Māori patients alike.

Overall, this experience was a threefold success, in that: 1) it provided the opportunity to put into practice the skills of taking a clinical history from a patient using Māori-focused models; 2) it allowed JT the chance to take stock of, and empowered her to take steps toward regaining control over, her health; and 3) it allowed me the chance to reflect upon our interview and to rethink some of my initial attitudes towards our meeting.

Discussion

In this case, a fourth-year undergraduate medical student applied the Hui Process and Meihana Model, two Māori-centred clinical interviewing tools, to assist him to conduct a culturally appropriate interview with a hospitalised Māori patient. In so doing, the student was able to achieve a successful interview, and appreciate that using these tools had allowed him to engage in a manner, and on a level, that resonated deeply with both him and the patient. While results may vary depending on the expertise of the individual student, it seems likely in this instance that the

effectiveness of the consultation was significantly enhanced by utilising this culturally congruent methodology.

As an indigenous health framework, the Hui Process and Meihana Model have been in practice across the University of Otago for seven years. In that time, they have been evaluated by medical students, health practitioners, Māori patients and whānau, and have been rated favourably, as clinically relevant frameworks that support health practitioners to work effectively with Māori patients and whānau.¹⁴

The University of Otago has, in recent years, adopted the Calgary–Cambridge guide to communication skills for medical students.⁶ Although this too comes from a ‘Western medicine’ cultural background, many of the studies on which the method was developed were derived from anthropological and cross-cultural studies. Interestingly, the Hui Process maps easily onto the Calgary–Cambridge model, particularly if the text around cultural diversity is applied.⁶ Figure 1 illustrates that, although the two interviewing models differ significantly in their epistemological roots, there are basic similarities in structure and intent, which renders them mutually compatible.

Given the unequal health outcomes for Māori and the burden of comorbidities this population suffers, it is imperative that our future doctors have the ability to identify and analyse contributing risk factors at both the individual patient level and also at a broader health systems level. It is all too easy as health professionals to point the responsibility for poor health solely at the individual patient and lifestyle factors, rather than exploring the societal inequalities in health determinants, the access to and quality of health care, and thus, ignoring the impact of factors generating and perpetuating health disparities.¹⁵

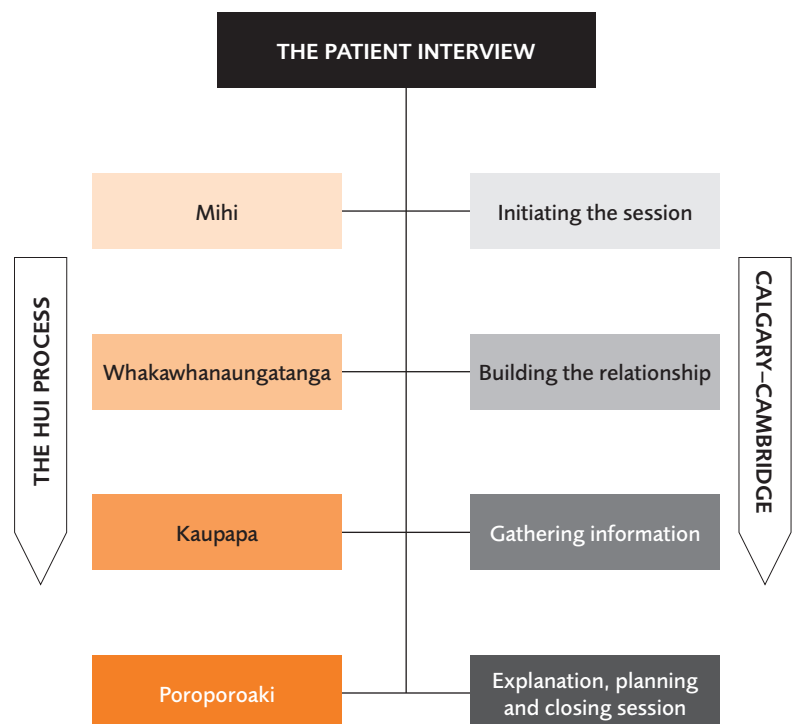
In a recent revision of the Meihana Model,¹⁴ further domains, such as Ngā Hau E Whā have been added, incorporating aspects of external societal influences that may impact on the patient’s health and wellbeing. Ngā Hau E Whā, literally translated as ‘the four winds’, incorporates factors such as colonisation, racism, marginalisation, and migration, and discusses the potential impact of

these on the historical and current health of the patient and whānau.

In the fifth-year undergraduate Hauora Māori training, students repeat the case study process outlined in this article, and are also required to incorporate a critical analysis of the underlying determinants of health that may have had an impact on the presentation, and the role of the health system in perpetuating or mitigating health inequalities. Such analysis would involve recognition of the significant burden of disease this patient faced, and consideration of the contributions of low self-efficacy, health literacy, intergenerational trauma, acculturation, urbanisation/migration, socioeconomic deprivation, differential life-opportunities, structural discrimination, and the availability of Kaupapa-Māori and/or culturally appropriate mainstream primary care services.

A further relevant issue raised in this instance, is the extent to which ethical values are culturally bound. Teaching around ‘boundaries’ discour-

Figure 1. Alignment of the Hui Process with the Calgary–Cambridge model



ages students from sharing their personal stories or continuing contact with a patient after seeing them; however, implicit within the process of whakawhanaungatanga, is the embodiment of genuine interest, concern, and hence obligation towards the patient. Ideally, this process requires the student/doctor to demonstrate this commitment through subsequent contact with the patient and appropriate follow-up. Most students who use this process manage to find ways to discharge this obligation within the parameters of an appropriate doctor/student-patient relationship (e.g. sitting with the patient until they go to theatre, coming back to the ward at a later time to meet whānau members when they are visiting, or 'checking in' with the patient daily for the remainder of their hospital stay). In the case presented, the student made the right call in 'flirting with the patient contact boundary' (that is, the student's email contact relating to the patient's health seems appropriate taking this into account, although not usual practice).

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He mihi poroporoaki
ki a koe e te Whaea.
Haere, moe mai, okioki.

We would also like to acknowledge the staff at the Māori Indigenous Health Institute (MIHI) of the University of Otago Christchurch for the initial development of the Hui Process and Meihana Model.

He mihi nui ki a koutou.

COMPETING INTERESTS

None declared.

If the outcome of a consultation with a Māori patient can be improved by having a more culturally congruent consultation model, to what extent should this encourage all health professionals to re-evaluate their consultation model with all their patients? If a broad view of culture is taken, then the majority of our patients are culturally different from ourselves and from the dominant Western medical view of the world, and perhaps it is time that the monochromatic mantra of the standard history taking format⁶ be recognised as too narrow and content-oriented. Broader approaches that retain a purposive clinical enquiry but better recognise the sociocultural context of the patient (such as the Hui Process and Meihana Model) need now to be accepted as the new norm.

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