

# The value of te reo in primary care

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## ABSTRACT

**INTRODUCTION:** The influence of indigeneity is widely recognised as a health determinant; however the impact of the utilisation of the indigenous language on health care has not been closely examined.

**AIM:** To explore the Maori language (te reo) as a determinant of health from a Maori patient's perspective.

**METHODS:** Maori patients were recruited through Maori health networks and the snowballing technique. Thirty participants participated in one of three focus group interviews. A semistructured interview explored the utilisation of health services, comfortability with service delivery and perceptions of general practice surgeries' cultural competency. Thematic analysis was utilised to interpret the data.

**RESULTS:** Te reo was recognised as an important cultural competency, noted by participants as contributing to the development of appropriate doctor–patient relationships and their feelings of being valued within a practice. Patient-led use of te reo was identified as most appropriate, an indicator of quality of care.

**DISCUSSION:** The training of primary care staff in te reo should be encouraged. Developed as a competency, this will see primary care settings better able to respond to Maori patients and in turn support Maori health gains.

**KEYWORDS:** Maori health; Maori language; family practice; quality health indicators

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## Introduction

The influence of one's ethnic culture, and more specifically indigenous culture, as a health determinant is well recognised.<sup>1–5</sup> However, the impact of utilisation of the indigenous language on health care has not been closely examined.<sup>6</sup> The current article examines patients' perceptions of the value of use of the Maori language (te reo\*) in primary health care settings.

Health disparities between indigenous and non-indigenous peoples have been well documented in New Zealand (NZ) and a number of other countries.<sup>7–10</sup> A range of factors have been identified as contributing to these disparities, with increasing evidence that variables relating to cli-

nician and institutional practice have a significant impact.<sup>11–14</sup> Such findings have prompted the development of strategies specifically for clinicians and health care providers to strengthen their capacity to support indigenous health outcomes. In the NZ health environment this has involved the promotion of cultural competency and safety, particularly in the health education sector.<sup>15</sup>

This provides a context in which to consider Maori health issues and explore/develop appropriate competencies and skills.<sup>16</sup> To date, inclusion of the Treaty of Waitangi, cultural protocols, communication strategies, epidemiological data and Maori health models, as well as facility in te reo have been identified as pivotal in increasing

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\* Te reo refers to 'Maori language' for the purposes of this paper.

the clinician's ability to work effectively with Maori patients and whanau.<sup>15,17-19</sup> The application of elements of te reo is the focus of the current article; specifically, data drawn from Maori patients' perspectives on determinants of quality in primary health care.

## Methods

The wider study from which the current data was drawn was conducted in 2001 and involved the evaluation of a Ministry of Health funding model used in contracting an Independent Practitioners Association (IPA).<sup>20</sup> This study involved a multi-methods evaluation approach to determine the efficacy of this funding model and its potential to be transferred to other IPAs. For the purpose of this paper, an aspect of the project, which involved Maori community perceptions of this IPA's health service delivery, is reported on.

Maori patients were identified and invited to participate through the local Maori provider

referrals were followed up by the research team and, utilising the general information form, were invited to participate in one of two further focus group interviews. All those invited to take part in the research agreed.

All participants were asked their ethnicity upon recruitment, using the Census 2001 question. Participants ranged in age from 25 to 70 years of age, with 19 of the participants being female. Participants ranged in work experience. At the time of the interview, 10 worked within the health environment, five were involved within the education sector, five were retired, eight worked in other fields of employment and two were not employed at the time of the interviews. Participants attended the same GP surgery each time (except in emergencies where they would access either the 24-hour after-hours clinic or the emergency department). The exact number of surgeries represented by the participant group was not specifically captured. However, the experiences shared within the transcripts highlight that these practices ranged across deprivation areas within Christchurch and were all

## Participants recounted many experiences of having their name mispronounced, and noted how this had led them to feel belittled or unwelcome in the clinic, discouraging them from attending again.

network. To be included participants needed to self-identify as Maori, be registered with a general practitioner (GP) from the IPA, and to have visited their GP at least four times in the previous 12 months. The latter criteria allowed participants to comment on the basis of multiple visits, as opposed to a single experience. Exclusion criteria included those who were under 16 years of age, and those deemed as cognitively unable to give personal informed consent.

Ten participants agreed to participate through the initial provider network recruitment strategy. Twenty more participants were subsequently recruited through a snowballing technique.<sup>21</sup> This involved the initial 10 participants identifying other friends/family/colleagues they knew who might be interested in participating. These initial

urban-based. Participants received a petrol voucher as koha for their time and sharing of knowledge.

For the purpose of this study, 30 participants were seen as adequate to provide the breadth and depth of experiences necessary to saturate any themes arising from the data.<sup>22</sup>

A semi-structured interview schedule was used to explore utilisation of health services, comfortability with service delivery and perceived cultural competency of their general practice surgery. Interview times were 1.5 and two hours respectively. All focus groups were audio taped and transcribed verbatim.

Data analysis took an inductive thematic approach in order to represent the patient voice

without imposing coding schemes. The interview transcripts were analysed by two researchers and broad themes identified. These themes were collated and condensed according to similarity. The final categorisation of themes resulted after four sorting procedures; consensus was reached throughout the process by the researchers agreeing on the category generation.

The Canterbury Ethics Committee reviewed and approved the complete research evaluation (CTY/01/03/031).

## Findings

Although the interview schedule did not ask specifically about te reo, this emerged as a significant theme in all focus groups. The results are presented below in relation to the three primary themes derived from the data.

### 1. Name pronunciation

“I would really like to have my name pronounced correctly.”

During discussion of barriers to care, participants were asked what constitutes ‘good health care’. The focus groups’ initial responses related to the medical receptionist pronouncing their name correctly. Participants recounted many experiences of having their name mispronounced, and noted how this had led them to feel belittled or unwelcome in the clinic, discouraging them from attending again.

“I hate that every clinic I’ve ever been into it’s always Ms X [mispronounced Maori name by medical receptionist] and now I don’t bother saying my name or any of my children’s names [correctly]. Things won’t change.”

“You are in the waiting room and you hear the receptionist/nurse go TTTTTTTTTT....and you sigh, get up and go in, you know it’s you.”

“You look at people that go to my doctors... a hell of a lot of Pakeha, every single thing is Pakeha. Right down to the abuse, verbal abuse of your name.”

Participants agreed that everyone in the practice (the medical receptionist, nurse and GP) pro-

## WHAT GAP THIS FILLS

**What we already know:** Increasing evidence has identified that variables relating to clinical and institutional practice have an impact on indigenous health outcomes.

**What this study adds:** The use of Maori language, patient-directed, is a variable that impacts Maori patients’ perceptions of quality care within a primary care setting.

nouncing their name correctly was a measure of ‘gold standard’ health care. They saw this, as not only a sign of respect, but also indicative of the GP’s intention to engage with them, as Maori.

“I get on a first name basis now in our medical clinic, it’s not very often you get called by your name correctly.” [Participant had a Maori first name.]

### 2. Relationship development skill

A second theme to emerge was that the use of te reo had assisted in the development of positive relationships between participants and their general practice surgeries. Although all patients spoke fluent English, there were times when they preferred to use te reo. The main reason for this was that they felt they were better able to articulate how they felt about their health condition and/or presenting complaint characteristics. Often this was conveyed by the use of one word (e.g. hoha) or a phrase (he mate au). It was also seen as an opportunity to share more with the general practice about themselves and their connection to the Maori world and Maori beliefs and values—including te reo.

There was an expectation by participants that their general practice surgeries would either know/understand these words or seek clarification. When general practice staff ignored or reacted to te reo negatively (e.g. body language or verbal commentary), participants took this as a sign that Maori perspectives were not valued, or seen as valid. Furthermore, participants also perceived this as a strong message that general practice did not want to develop a relationship with them. Such negative experiences had led some participants to disengage with the health system for a period of time.

"They ask you how you feel and you say hoha, and they say what? ...waste of time... they just don't get you... so you say nothing."

Participants reported feeling high levels of satisfaction and having enhanced connection with primary health care providers who did engage in te reo, either by repeating Maori words used, or seeking further clarification of the word/phrase meaning. Participants perceived a general practice prepared to attempt te reo as more 'trustworthy'.

"My GP was a good doctor... I would go in there and I could say xyz [words in te reo] and there was a relationship."

It is interesting to note that for participants the relationship was seen as pivotal to the quality of health care; several noted that if their GP moved surgeries they would follow, in order to maintain the relationship. Some participant accounts saw whanau travelling for more than 40 minutes to maintain continuity with that GP.

### 3. Quality of care indicator

Participants identified that Maori visual media (such as posters, signs and brochures) alone were not sufficient as a sole mechanism for engaging with Maori patients. Such efforts were seen as tokenistic, as indicated by the following brief conversation:

Interviewer: "How would you define tokenism?"

P1: "Seeing a Maori bear sitting in the corner..."

P2: "...or Manu doll"

P3: "...or just a 'haere mai' sticker or something on the door like that..."

The use of te reo was seen as an important non-tokenistic indicator of cultural competency. Overall, participants felt strongly that future health care for Maori should encompass the use of te reo as a quality indicator.

"I mean the ideal that being like a culturally-sensitive experience is right out there, it's sort of like the year 2020. I'm hearing kia ora when I

walk through the door... I'd like it to be but it's sort of dreaming. That's where I'd like to take my children... somewhere like that."

All participants agreed that use of te reo should be patient-led. However, they clearly identified that if patients do use te reo within the general practice setting, it needed to be valued and responded to in a positive way.

## Discussion

This study highlights the value of te reo usage within primary care, as perceived by participants. This can be as simple as making an effort to correctly pronounce patients' names and to utilise te reo spoken by the patient. Te reo was clearly identified as assisting in relationship-building between clinician and patient and as an indicator of quality health care.

Over the past decade there has been a trend towards the use of te reo in health promotion, reflecting both increasing numbers of te reo speakers within NZ and recognised benefit of providing targeted health care messages/interventions.<sup>23,24</sup> The use of te reo is seen as a core cultural competency central to enhancing communication and engagement. More specifically, te reo can be a vehicle to better understand cultural protocols (tikanga) and Maori health perspectives. However, in order to be sensitive and responsive to individual Maori patients, clinicians should mirror patients' use of te reo, rather than assume fluency or acceptability.

International attempts to develop a range of cultural competencies have tended to focus on clinician knowledge of health disparities and eliciting patients' health beliefs.<sup>25-27</sup> The value of clinicians' adoption of indigenous language as a key cultural competency and clinical skill has not previously been explored.

There are a number of limitations within this study. Firstly, the participant group was drawn from a single community and it is unknown whether similar beliefs are held throughout Aotearoa. Secondly, the inclusion of health care workers within the focus groups may also limit the generalisability of conclusions drawn in this

study to Maori patients in general. Additionally, the absence of adolescent participants within this study means that we were not able to explore the value of te reo to younger Maori in this context, a group amongst whom there is increasing usage and fluency. Finally, whilst the use of te reo was valued by these participants, it remains to be shown whether use of te reo in primary care will ultimately affect Maori health outcomes.

However, despite these limitations it is clear from the study findings that use of te reo can significantly enhance the experience of Maori patients in general practice and primary care. From the perspective of strengthening service responsiveness and therefore quality, staff within primary health care providers ought to be encouraged to improve their pronunciation and use of te reo. This is a powerful symbol of provider interest and willingness to engage meaningfully, can assist in understanding a patient's health beliefs and, ultimately, foster a stronger therapeutic alliance.

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## COMPETING INTERESTS

None declared.