‘...but I just prefer to treat everyone the same...’: general practice receptionists talking about health inequities

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Abstract. General practice receptionists are positioned at the beginning of a patient’s journey within the healthcare system, yet their influence on a patient’s experience is unknown. The limited data on, and research involving, general practice receptionists both in New Zealand and internationally is evidence of this. This research undertook an exploration of the discourses used by a group of general practice receptionists in Wellington, New Zealand to discover how they talk about, and represent, health inequities. Eight in-depth semi-structured interviews were conducted, guided by Social Constructionism and Decolonising Theory. Three reoccurring patterns of discourse were identified: discourses about the social determinants of health; discourses about Māori culture and behaviour; and discourses about egalitarianism. Further, narratives that could be seen as deficit-focused or victim-blaming were identified. Racism was not directly discussed by participants as a health determinant. The findings support the need for training guided by cultural safety and anti-racism principles to be available for all general practice receptionists.

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Introduction

General practice receptionists (GPRs) are an under-researched group of healthcare workers, both in New Zealand and internationally. This is evidenced by the limited data about, and research involving, GPRs. As such, their influence on a patient’s experience within the healthcare system is generally not well understood. In addition, little is known about the way in which GPRs conceptualise health inequities in New Zealand.

It is well documented that persistent health inequities exist between Pākehā and Māori (Reid and Robson 2007; Harris et al. 2012). There is also strong evidence demonstrating that experiencing racism can negatively influence health (Harris et al. 2012; Paradies et al. 2015). Racism shapes exposure to the determinants of health (Reid and Robson 2007), and can have a direct effect on health through racially motivated violence, as well as via chronic stress pathways (Paradies et al. 2015). Racism has also been shown to have an effect on health access, quality and experiences (Harris et al. 2019). Relatively less research has explored the potential for racism to operate via healthcare providers’ discourses about ethnic groups and impact healthcare outcomes and inequities.

Discourses, as ‘patterns of talk’, play a central role in transmitting and perpetuating racism in society (Tuffin 2008; Wodak and Meyer 2009). In this study, discourse is understood as both social action and a function for constructing and representing the social world, including the (re)production of identities, realities (Jorgenson and Phillips 2002) and unequal power relations (Wodak and Meyer 2009). Discourses order and institutionalise ways of talking and thinking (Jager and Maier 2009). Within the talk of clinical health professionals, stereotypical and potentially harmful patterns of discourse about Māori have been identified (McCreeanor and Nairn 2002; Penney et al. 2011). Internationally, research shows that this phenomenon is also present in clinical health professionals’ narratives about Indigenous patients (Kowal and Paradies 2005; Tang and Browne 2008).

Although the role of the GPR may differ across primary care settings in New Zealand, the GPR is often the first point of contact for a patient and thus is integral in shaping a patient’s first impression of the health service and the ongoing patient–provider relationship for the short- and long-term. This role has been identified as critical, bridging the healthcare system and the community (Neuwelt et al. 2016). This paper explores the ways in which GPRs talk about Māori health and health inequities to gain insights into the potential effect of such discourses on the experiences of Māori within the primary healthcare system. We hypothesised that the patterns of talk of GPRs may reflect previously identified patterns of talk identified among other health professionals.
The focus of data analysis centred on the discourses of individuals, as the goal of a CDA approach is to examine the discursive resources used rather than to judge participants on their knowledge or positioning in relation to the phenomena (McCreanor and Nairn 2002). This paper focuses on the identification of tropes and discursive patterns rather than semantic moves. Although not a primary aim of the project, valuable data were gathered about the role of GPRs, including favourite and least favourite aspects of the role, their views on training opportunities and experiences and what effect they believe their role has on patients and, in a broader context, on the health system. These data are reported elsewhere.

Methods

This study was carried out in the Wellington region of New Zealand. Following ethics approval from the University of Otago Human Ethics Committee (D15/001) and advice from the Ngāi Tahu Research Consultation Committee (University of Otago n.d.), all primary healthcare organisations (PHOs) covering the Capital and Coast and Hutt Valley District Health Board areas were informed of the proposed study. General practices within the Greater Wellington region of Wellington, both urban and suburban, were eligible for inclusion. Independent practices (i.e., those not affiliated with a PHO) were excluded to maintain structural homogeneity. Randomisation using Microsoft Excel (Microsoft Corporation, Redmond, WA, USA) was carried out to prioritise the order of contacting general practices, who were then approached through a staggered method. As little was known about those working as GPRs, the inclusion criteria for participants was as open as possible, requiring participants to be over age 18 years and to have worked as a GPR for at least 1 year before the date of recruitment. The latter requirement was intended to allow for participants to have been in the role a sufficient amount of time to be able to talk about their experiences as a GPR. Of the 59 practices that met inclusion criteria, 39 practices were approached, with eight participants recruited for the study. As this was an exploratory study, we intended to recruit a relatively small number of participants from a range of practice settings.

Semi-structured interviews were undertaken using behavioural and responsive interviewing methods. The interview schedule was informed by a comprehensive literature review. In order to obtain the most information possible, the interview schedule was developed into five broad themes. These included: (1) identity and role of the participant; (2) participants view on the role of the GPR; (3) understanding of Māori health and health inequities; (4) experiences working with people of different cultures; and (5) knowledge and use of Te Tiriti o Waitangi (the Treaty of Waitangi). All interviews were undertaken by the lead author and audio-recorded with the permission of participants. Interviews were between 20 min to 1 h long. Food and vouchers were provided to acknowledge participation and establish whakawhanaungatanga (relationship building). Anonymity of participants was maintained using pseudonyms. Participants were informed from the outset that written transcripts of their interview would be made available in order to check for accuracy. All participants were sent a summary of interview findings once analysis of the data was complete.

A broad critical discourse analysis (CDA) method was used to analyse the data. Analysis of the data was guided by a framework created by the researchers following a comprehensive review of existing discursive techniques. Critical notes were taken throughout the analytical process, including notes about both novel themes and themes previously identified within the study of racist discourse such as individual responsibility as the norm, culture as a burden, fairness and special treatment, one people or togetherness, genetic predisposition, history and hypersensitivity of the ‘other’ (Nairn and McCreanor 1991; McCreanor and Nairn 2002; Tuffin 2008; Penney et al. 2011).

The findings from this exploratory research reflect how a small group of GPRs in one region of New Zealand talk about health disparities. Through analysis of the transcripts, three themes were identified: discourses about the social determinants of health; discourses about Māori culture and behaviour; and discourses of egalitarianism.

Discourses about the social determinants of health

Participants demonstrated awareness of several determinants of health and their implications for Māori accessing health care in their discourse, including housing and education. Housing was cited as a potential cause of poor health by several participants, demonstrating an understanding of socioeconomic explanations of poor health.

...and even living conditions at home like around [the clinic location], there’s a lot of state housing and those houses will not be warm. My flat’s not warm either you know? So it’ll be pretty cold and yeah, the basics of when you get sick, like trying to stay healthy, like warm and stuff, I don’t know if that’s maybe umm done as well as it probably could [P01].
Education or an ability to understand the health system, both as a barrier and a solution, also recurred in participants’ discourses that attempted to explain why Māori have poorer health than non-Māori. In the following example, one participant frames this within a context of health literacy and communication between the doctor and the patient.

...people say, ‘oh, that’s their fault they’re down at KFC’ and make massive assumptions but is some of it down to that point of contact when they’re in the doctor’s room and giving them other options and taking a bit more time with individuals to break the cycle and I know the doctor tells me stories and she’s tried with certain patients and different topics for three years, and obviously, come back, same conversation but then sometimes the lightbulb goes off and it changes then, which is pretty awesome [P01].

In discussing social drivers of health and health inequities, the theme of competing priorities was identified. This was particularly evident in relation to poverty, finance and perceived cultural norms, behaviours and social organisation, such as in the excerpt below.

...I don’t come from a massive family myself but if you do, would the care be a little bit more overlooked because there’s so many more people to look after and feed and all those things so the basics become the true basics...I dunno, some people view coming here as like there’s so many other things they need to do and this isn’t top of their priority list whereas some people you know, your health is everything and maybe for other people there’s you know, until it gets so so bad that’s when you go see a doctor, maybe there’s more of that mentality [P02].

Discourses that could be seen as victim-blaming were also identified. In these discourses, the causes and solutions for health inequities were constructed to lie within the realm of responsibility of Māori; for example, through the reference to ‘their bad lifestyle’.

You know, is it targeting some of the lower socioeconomic people or is it just people that have developed conditions because of their bad lifestyle...? [P04].

Such references to the social determinants of health may reflect a growing understanding of the influence of wider socioeconomic factors on health and healthcare behaviours. However, within the context of broader social drivers of health, explanations that focussed on the individual and their decisions or behaviours were identified. In contrast, no explicit connections to, or mention of, colonisation, institutional or systemic racism as social determinants of health were made by participants.

Discourses about Māori culture and behaviour

Discourses referencing the culture and behaviour of Māori (and Pasifika) were also identified. Stereotypical perceptions of Māori patients, such as shyness, passivity, a fatalistic attitude, large and uncontrolled families and impulsive and deviant behaviours around health were drawn on in participants’ discourses.

The interpretative repertoire of culture as a burden, previously identified by McCleanor and Nairn (2002), was deployed in GPR discourses to convey examples of a perceived misfit between the Māori patient and the health system. In almost all cases of use in this study, the Māori patient, and the participants’ understanding of what constitutes Māori culture, is positioned as at fault and incompatible with the structure and design of the healthcare system.

...I’m not actually too sure how we can sort of encourage them [Māori] to come in um...I think maybe making it more culturally acceptable in their, like their own elders encourage them to come in... [P05].

Shyness, shame and an inability to communicate were conceptualised as common characteristics of Māori within participants’ discourse. Again, the problem is situated with the Māori patient. The employment of a comparison group is apparent in this excerpt, through the use of the loaded term ‘normal’; however, this group remain unnamed and vague.

...and maybe it’s embarrassing, like um you get all sorts of people like, that come in and do a urine sample, to me that’s like not embarrassing um whereas some people completely you, you [sic] can see they feel really awkward about it yet it’s fine...maybe it’s quite a normal, good thing to look after yourself [P01].

The theme of fatalism was present in the discourse of participants. The following explanation portrays Māori as unwilling to face responsibility and reality (such as a health intervention), instead preferring to leave their future up to fate.

...um fear of the you know, rather than fear of the unknown they’ve been given a little bit of information but actually, if I don’t know any more, it won’t affect me – sort of head in the sand type thing...yeah [P03].

The theme of control or a lack of control was identified in relation to Māori families, behaviours in the waiting room and the assumed ‘impulsive’ behaviour of Māori individuals. One participant utilised negative storytelling (van Dijk 1987) to illustrate a perceived experience of the lack of control within Māori whānau, contrasting ‘good’ Pākehā behaviour with that of Māori. The participant in the excerpt below makes reference to the relative lack of clothing worn by the Māori or Pasifika children in the excerpt. This detail strengthens the visual contrast.

...they’ll come in and, I dunno, it seems a lot, like not sounding awful, but it seems a lot less controlled. So the [Māori or Pasifika] kid will be like running outside and stuff and they’re sick and they don’t have many clothes on whereas when you get like, a white mum and a baby and it’s warm and like a very different relationship whereas the families are bigger and there’s less control on what they do [P01].

A lack of trust in the mainstream health system, of health professionals and of other cultures, are ideas expressed in the discourses. The interpretative repertoire of mistrust can be associated with the hypersensitivity of Māori repertoire when framed as victim-blaming discourse (Moewaka Barnes et al. 2012). Framed as a characteristic of Māori culture, this theme has the effect of portraying Māori as hypersensitive and overly emotional (Nairn and McCleanor 1991). The following excerpt demonstrates this.
Talking about health inequities

We don’t really have this problem [of health disparities] in our practice because all Māori and Pacific Island patients are with us [sic] have been with the doctors for the entire time that I’ve been there and came with them from their previous practices and really trust them [P06].

Discourses of egalitarianism

Strong notions of egalitarianism were also identified within participants’ discourses, demonstrating the widely available belief that healthcare systems and services treat all patients equally. Such discourses were most commonly used in response to questioning about the role of Te Tiriti o Waitangi—the legal document formalising colonial New Zealand (Archives New Zealand – Te Rua Mahara o te Kāwanatanga n.d.)—and the unique position of Māori as Indigenous peoples. It is apparent that when unsure, the interpretative repertoire of treating everyone the same is prominent in descriptions of approaches to patient discomfort.

... you know I mean it’s [Te Tiriti o Waitangi] part of our lives of everybody [sic] in this country. But um, I just prefer to treat everyone the same [P05].

Although such explanations may produce positive outcomes, they do not reflect the principles of Te Tiriti o Waitangi and instead, appear to support multiculturalism over the colonised–coloniser relationship.

Discussion

This study identified persistent and longstanding stereotypes about Māori within the talk of participants without any reference to structural, historical and political explanations, demonstrating that such explanations are perhaps not as easily available or cognitively accessible to GPRs (van Dijk 1997). There is strong evidence to suggest that stereotypes are present in healthcare interactions (Penney et al. 2011). This is known to have major implications for Māori accessing and receiving care (Buetow et al. 2003; Reid and Robson 2007), adding to the often stressful and unsettling experience of attending a healthcare service. For example, the use of the traditional stereotype of ‘whakamā’—a behavioural or attitudinal characteristic of Māori defined by Pakehā as similar to fear, embarrassment, shame, shyness, indignity or feelings of inferiority or inadequacy (Sachdev 1990)—was referenced by participants as a cultural deficit of Māori that results in poor health outcomes. By attributing whakamā to a constitutional characteristic of Māori, the real causes of this behaviour—loss of mana (prestige, authority), concern for breaching tapu (sacred, restricted or protected items or practices) and a result of the pain of colonisation—go unacknowledged (Buetow et al. 2003). Indeed, early clinical definitions of whakamā perhaps better describe stereotype threat (Aronson et al. 2013) and a natural response to colonisation and racism.

The egalitarian discourses identified in this study have also been evidenced in the talk of clinical health professionals about Māori (McCreanor and Nairn 2002). This pattern of discourse disregards the role that historical and political forces play in creating and sustaining health and wellbeing inequities, and instead places the responsibility for health squarely on the shoulders of individuals and their health behaviours. The use of such classic interpretive repertoires in relation to Indigenous rights is not exclusive to New Zealand; for example, exploration into the discourses used by health professionals about Aboriginal Canadians found strikingly similar patterns of talk (Tang and Browne 2008).

This exploratory research was conducted with a small sample of GPRs within the Wellington region. While this was in line with the expectation of a CDA approach (Wodak and Meyer 2009), further research would be required to determine if the patterns of talk identified in this study are also evident among GPRs across New Zealand more generally. The utilisation of a qualitative methodology has allowed for the collected data to be rich, less constrained and contextualised within the lived realities of participants. Through a CDA approach, discourses are able to be analysed as entities in and of themselves (Wodak 2001), a characteristic that lessens the risk of problematising and blaming participants for using unhelpful discourses. This feature, therefore, has allowed for the identification of unhelpful patterns of discourses that locates them within a broader system of racism, whereby GPRs are likely to be exposed to a range of racialised discourses about Māori patients and Māori health, both through their work and in society more broadly.

This study supports the need for training for GPRs, guided by cultural safety and anti-racism principles. It appears that there is not currently any requirement for GPRs to undertake this type of training, and support and resources for the training is dependent on individual employers. Finally, the collection of national data on the demographic identities of the GPR population alongside that of clinical and non-clinical health professionals is recommended.

The results of this study highlight that the discursive resources available to GPRs do not always support the inclusion of Indigenous peoples into the mainstream primary healthcare system. As the individuals who must prioritise, monitor and make judgements about all who enter the healthcare system, more recognition and support is needed to reduce any negative influence that may result from limited knowledge, insufficient training, time pressures or feelings of powerlessness.

Conflicts of interest

The authors declare that they have no conflicts of interest.

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