August 2018

Adult Māori Patients’ Healthcare Experiences of the Emergency Department in a District Health Facility in New Zealand.

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Recommended Citation:

https://doi.org/10.18357/ijih.v13i1.30300
Adult Māori Patients’ Healthcare Experiences of the Emergency Department in a District Health Facility in New Zealand.

Abstract
Globally, there are significant inequalities and disparities in health service delivery to Indigenous populations, including Māori in Aotearoa/New Zealand. This study explored the experiences of adult Māori patients in the emergency department (ED) of a district health facility in New Zealand. Qualitative research exploring the ED experiences of Māori patients is limited. Two semistructured interviews with 4 Māori participants were conducted, audio-recorded, transcribed, and thematically analysed with the help of the Māori health department within the hospital. The participants identified 3 main areas of improvements relating to (a) the ED environment, (b) the interactions with healthcare professionals (HCPs), and (c) the unique factors faced by the kaumātua (Māori elders). The main conclusions were that aspects of the ED environment, including the room layout and lack of privacy, could negatively influence Māori ED experiences. In addition, HCPs not adequately integrating the Māori view of health in their clinical practice also had a negative influence. The kaumātua faced unique challenges, including the language barrier and lack of sufficient information from HCPs during their patient journey. Educating HCPs and making the ED environment more sensitive to Māori could improve their experience.

Keywords
Māori, healthcare, emergency department, experiences, qualitative, interview, New Zealand

Glossary
karakia: traditional prayer
kaumātua: Māori elders
kaupapa Māori: Māori approach, principles or customary practice
manaakitanga: the way in which you receive, host, and care for visitors when they are with you
marae: traditional meeting place for Māori
mauri ora: healthy individuals
mihi: greeting, paying tribute
noa: the normal state of being
Te Reo Māori: Māori language
tikanga: correct procedure, protocol
wai ora: healthy environments
whakamā: shame or embarrassment
whakapapa: ancestry informing a person’s origin and identity
whakawhanaungatanga: the establishment of meaningful relationships
whānau: family
whānau ora: healthy families
whanaungatanga: a relationship, kinship, sense of family connection
Acknowledgements
The authors wish to thank the following:
• the four participants of this study who kindly gave up their time to share their stories and experiences of health provision;
• the Regional Māori Services, Bay of Plenty District Health Board, Tauranga Hospital, New Zealand;
• Emergency Department, Tauranga Hospital, New Zealand; and
• the University of Birmingham’s Sir Arthur Thomson Trust Scholarship Elective Prize, providing financial support for SGA’s travel to and stay in New Zealand.

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**Introduction**

Globally, Indigenous populations experience a greater burden of disease than non-Indigenous populations (Gracey & King, 2009; United Nations Inter-Agency Support Group on Indigenous Peoples’ Issues, 2014; Wilson & Barton, 2012). Māori experience this inequality and are more likely to have poorer health than their non-Māori counterparts, including a higher mortality from cardiovascular disease and a higher prevalence of respiratory disease, diabetes, and mental illness (Ministry of Health, 2015; Reid & Robson, 2006; Ring & Brown, 2003). The cause of this inequality is complex, owing to a variety of socioeconomic and lifestyle factors as well as racial discrimination and the impact of colonisation (Blakely, Tobias, & Atkinson, 2008; Ellison-Loschmann & Pearce, 2006; Harris et al., 2006; Reid & Robson, 2006; Wilson & Barton, 2012).

The Māori view of health is holistic and takes into account mental, emotional, familial, and spiritual wellbeing alongside physical health (Cram, Smith, & Johnstone, 2003; Durie, 2001; Rochford, 2004). Western medicine primarily focuses on physical health and therefore Māori patients may find this approach to healthcare lacking (Durie, 2001; McCreanor & Nairn, 2002). Ellison-Loschmann and Pearce (2006) and Reid and Robson (2006) suggest that good-quality healthcare for Māori occurs when healthcare is delivered in a culturally responsive manner. Māori healthcare professionals (HCPs) make up a small proportion of the workforce, and therefore non-Indigenous HCPs are more likely to care for Māori patients and may need specific training to deliver culturally appropriate care (Ratima et al., 2007; Wilson & Barton, 2012). Furthermore, the Treaty of Waitangi, a set of principles that empower and protect Māori people, guarantees their right to equal healthcare (Ellison-Loschmann & Pearce, 2006; Wilson & Barton, 2012). There are professional cultural competence standards and legislative requirements with regards to the treaty that HCPs need to adhere to if they are to maintain their practising certificates, including an active approach to integrating Māori health beliefs in medical practice, shared decision making between non-Māori and Māori people, and Māori autonomy and authority over their healthcare (Health Practitioners Competence Assurance Act, 2003; Nursing Council of New Zealand, 2005; Wilson & Barton, 2012). The Western construct of medicine provides little flexibility to accommodate alternative views of medicine, and hence the impact of colonisation may continue to hinder the inclusion of Māori health beliefs in current practice (Dodgson & Struthers, 2005).

Previous research on healthcare delivery has looked at the experiences of Māori patients in general practice, secondary care, cancer services, and psychiatric services (Dew et al., 2015; Johnstone & Read, 2000; McCreanor & Nairn, 2002; Wilson & Barton, 2012). Johnstone and Read (2000) and McCreanor and Nairn (2002) found that some general practitioners and psychiatrists displayed stereotypical thinking about Māori and made racist remarks. The emergency department (ED) is a different setting and may present unique challenges to the treatment of Māori. Managing acutely ill patients and triaging a large number of patients in ED can lead to quick judgements being made, increasing the risk of assuming stereotypes and hence negatively impacting the treatment of Indigenous people (Richardson, Babcock Irvin, & Tamayo-Sarver, 2003; van Ryn & Fu, 2003). Internationally, studies have shown that there are
ethnic inequalities within ED care, manifesting as Indigenous children having longer wait times and more Indigenous patients leaving ED before being seen, compared with their non-Indigenous counterparts (Park, Lee, & Epstein, 2009; Thomas & Anderson, 2006).

Studies examining Māori health experiences in the ED are sparse. The He Ritenga Whakaaro study looked into the experience of Māori patients in health services and provided some insight into ED care (Jansen, Bacal, & Crengle, 2008). They found that Māori experiences were largely influenced by the behaviour and attitude of the hospital staff and their interactions with them (Jansen et al., 2008). Further qualitative exploration of Māori ED health experiences appears to be needed, and this study plays a role in addressing this literature gap.

Methods

This study used a qualitative approach that applied semistructured interviews to examine Māori health experiences in ED. A list of all adult Māori patients presenting to ED in the 2 months prior to the interviews was obtained from the health facility. The criteria applied are summarised in Table 1.

Table 1

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
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<tr>
<td>Patients who were discharged from the emergency department after their visit.</td>
<td>Patients with mental illness.</td>
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<tr>
<td>Participants with ages from 25 to 50 years.</td>
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The district health board’s Māori health department stated that kaumātua may be less open to being interviewed from an outsider’s perspective, and hence the age range was set to 25 to 50 years.

Individuals meeting the above inclusion criteria were telephoned and those interested were sent information sheets via email or post. Those still interested confirmed an interview date. Interviews were conducted in the district health board’s Māori health department. Two female patients (aged between 30 and 40 years) volunteered and each brought a female guest with them (both over the age of 65), making the total number of study participants four. Though kaumātua were initially excluded in the recruitment of study participants, they were able to participate in the study because their presence was at the request of the recruited volunteers.

All four participants were offered the choice of English or Māori for the interviews and the presence of a Māori health representative. They were also provided with petrol/taxi vouchers to cover travel costs. Interviews were conducted in English and followed Māori Health Services tikanga/kawa protocols whereby the interviews were opened and closed with karakia and whakawhanaungatanga to provide an authentic and safe connection between the interviewer and participants. All participants
received refreshments as an act of manaakitanga. Refreshments also played a role in reinstating noa, to allow the participants to return to their normal activities.

**Data Collection**

Two semistructured interviews were conducted and audio-recorded with participants’ consent. The interviews used a mixture of open- and closed-ended questions to ensure key aspects of ED care were covered as well as giving the participants the opportunity to talk about Māori health issues more generally. The key questions explored the participants’ individual experiences in ED and what they felt could be improved in the future.

**Data Analysis**

The audio-recordings of the interviews were transcribed manually to preserve meaning. Māori phrases were translated with the help of the hospital’s Māori health department. Field notes were written during the interviews to provide additional context. The transcripts were examined to identify recurring themes and subthemes and these were manually tabulated to aid interpretation.

**Relationships**

Ethical approval was obtained from the district health board and the New Zealand Ministry of Health’s Health and Disability Ethics Committee. Participants received an information sheet with contact details prior to the study, and verbal and written consent were obtained before participation. Interviewees were asked if they wished to read the transcripts prior to data interpretation. Confidentiality was preserved by the removal of participant-identifying information from the transcripts. The recordings were destroyed following data transcription.

**Results**

The study had a total of four Māori participants, all of whom were female. Each interview had a female participant aged between 30 and 40 years and a second participant aged greater than 65 years. All participants highlighted the proactive nature of the nursing staff in the ED as well as the knowledgeable and often empowering approach of the doctors they encountered. The three main themes in the study (Table 2) relate to (a) the ED environment, (b) interactions with HCPs, and (c) unique factors for the kaumātua. The subthemes generated are discussed within these themes.

**Emergency Department Environment**

**Room layout.** The interaction between the layout of the ED environment and health was discussed, with participants stating that the layout directly affected their perception of their own health and wellbeing.

> It was the seating arrangement in ED. I found it really hostile. The seating is normally, like, all the chairs go against the walls so everyone can see one another but this particular
day when I came in, all the seats were sort of like rows. And you could only go up on one side. And you had to sort of squish in and I didn’t like it because I found that I felt, like, claustrophobic. It was quite a hostile environment because you didn’t know who was behind you. I felt like I had to keep checking around me.

We’re aware of our surroundings. And I think all of those factors inform us about our wellbeing. Like all those little things. To the point of how we’re seated in the ED room. (Participant).

Table 2
A Summary of the Themes and Subthemes Generated from Data Analysis

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
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<tbody>
<tr>
<td>Emergency department environment</td>
<td>Room layout&lt;br&gt;Whānau presence</td>
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<tr>
<td></td>
<td>Spiritual assistance&lt;br&gt;Wait times&lt;br&gt;Distinction between public and private spaces&lt;br&gt;Use of Te Reo Māori and pronunciation in emergency department</td>
</tr>
<tr>
<td>Interactions with healthcare professionals</td>
<td>Appreciation of Māori knowledge of their own body and health&lt;br&gt;Introductions&lt;br&gt;Continued Māori cultural training for healthcare professionals</td>
</tr>
<tr>
<td>Unique factors for the kaumatua</td>
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</tbody>
</table>

In this particular case, the patient registered a complaint with the hospital and it was dealt with and the seats were returned to their previous position. She also recounted an experience where the limited space in ED meant that she had to use chairs as a bed:

_There were no beds left so they gave me chairs like this. They had no arms so they just grouped them together. And I had to wait for a few hours. I remember I had to lie down, but I laid down on the chairs. It’s chairs, because that’s where we put our bums. The idea of having to do that really made me feel quite sick. Having to lie on a chair and put my head on a chair. Was almost offensive, culturally. (Participant)._ 

These examples show how the physical layout of a room can directly affect patients’ physical health and how comfortable they feel in the hospital environment.

_Whānau presence._ Whānau was identified as an important part of Māori health. Some interviewees acknowledged the limited space in ED meant there was little room for whānau, stating that
“whānau can wait,” and that sometimes whānau can make situations more stressful. Other interviewees stressed the importance of whānau in the healing process, making links to spirituality:

If they know that their mama or someone is there that they know, they’ll heal quicker! Families when they have loved ones in here who are really sick, they’ll come in and do prayers (karakia). (Participant).

Furthermore, they discussed their frustration with the ED environment making it difficult to do this—for example, when faced with judgemental attitudes of some healthcare professionals towards their whānau.

I’ve always thought that they thought that we were taking up too many chairs. That should’ve been there for other people. People that are ill. They think we’re a noisy lot. But our songs are prayers. I’ve heard the nurses saying to them, “Oh, should’ve brought the whole tribe.” But it’s like our support because they’re all stressed. (Participant).

Spiritual assistance. Māori believe that spiritual health is a component of their health and wellbeing. The interviews portrayed different levels of spiritual need. In the first, spirituality was not a prominent factor: “Like a prayer if I’m sick? I do, but quietly to myself.” In the second interview, spirituality was more significant. One interviewee recounted the benefits of having a Māori cultural support person during one visit and believed it should be more readily offered in ED:

I think it will also encourage that, if they don’t want to take a religious side, then they can offer that support role for that person. And then engage with the family if there is a family for that person.
I think that could help reduce stress or reduce worry about the operation or whatever we’re facing is by offering them some kind of karakia (prayer) or some form of practice. And I think on the ED form when you sign in, I think it’s got something in there, if you want a chaplaincy. But I think it needs to be verbally made.
It could be from a small cultural practice like blessing the bed. You know when people die on the bed, well, we have a belief system that the residual of that person’s spirit can possible remain in that bed or in that room. I think it needs to be offered and talked about more in hospital/ED. Offer those services. But get clear on what you can offer to people.

Wait times. The interviewees mentioned dissatisfaction with the long waiting time in ED. However, they all believed that triaging was generally done fairly. They highlighted a particular problem with kaumātua waiting and their temptation to leave. Participants stressed that the kaumātua are heavily respected and hence, the idea of them waiting for a long time was more challenging to accept.
A friend of mine, she said her parents, were over 80, waited for 9 hours before the parents said, “It’s ok, we’re going to go home now.” (Participant).

Some nurse came out and shoved me in ED and then the doctor came and he goes, “Woah, you have to go to theatre straight away!” But I had been sitting in ED for 4 hours. Mind you, ED was full, I suppose they take the emergency ones first. Which is ok ... but I had nearly walked out. And I said why don’t you just hurry up and do whatever you’re gonna do, do it! And get it over with or else I’ll go home. (Participant).

**Distinction between public and private spaces.** The busy environment of ED can lead to the blurring of public and private areas and elicit feelings of *whakamā*. Participants may feel overly exposed and distressed in public spaces. One interviewee reflected on an experience when her blood pressure and temperature were measured in the waiting room.

*They used to take you to the side room. But now they don’t, they just do it all right there. There is no privacy whatsoever. I mean even if you try and whisper it’s still uncomfortable because there is another person right there waiting to sign up.* (Participant).

*Also, because not everyone is dressed appropriately for that too. You’re exposing yourself, your body parts. And you’re having to have that conversation in public. I don’t want everyone knowing my business. We’re quite private in that way.* (Participant).

**Use of Te Reo Māori and pronunciation in emergency department.** Te Reo Māori is one of the official languages of New Zealand, the others being English and New Zealand Sign Language. The use of Te Reo Māori in ED was appreciated by one of the participants. Having the Māori word next to an English word felt more inclusive and gave a sense of ownership over their health system.

*I like what they’ve got in ED what it says in English and then Māori underneath or Māori next to. Or like, how to wash your hands and they’ve got it written in Māori, I like that. Especially for the young kids growing up. You know, they understand.* (Participant).

*They (medical students) always ask my dad how do you say hello and goodbye. Things like that. They’re always asking, which is good. Keeps them interested in. So yeah, I’m happy with it.* (Participant).

In addition, another participant highlighted the importance of names, recommending HCPs take an interest in Māori names as well as confirming the pronunciation in a polite way.
I think it would be nice if the doctor or the nurse or whoever tries or attempts it. And then checks with the person. I think is more respectful. (Participant).

Our names are really important to us. Because I’m named after [community name] where I come from and it’s a really special place. So I get a little bit peeved off when it’s not done properly. (Participant).

Te Reo Māori holds the narrative and knowledge to maintain the continuation of Māori cultural rights and practices, and therefore mispronouncing names, without effort to do otherwise, can be perceived as rude and as devaluing the individual involved.

Interactions with Healthcare Professionals

Appreciation of Māori knowledge of their own body and health. Having an awareness of one’s own body and health was mentioned in both interviews. One participant described it as Māori having an “innate connection” with themselves. Having this belief may lead to conflict with HCPs who have alternative ideas. Interviewees described experiences of conflicts like this outside the context of this hospital’s ED, with one interviewee stating, “I know my body and you don’t.”

It should be natural for us to say—this is how my body is talking to me and how I actually feel, intuitively, and I know it to be this way. (Participant).

An appreciation of this Māori belief can be conveyed by giving patients choice. One interviewee spoke of a good ED experience she had where she was informed about a range of treatment options and was told that she could ultimately decide.

That was really good because they were thorough. And then they went away and then they came back and asked me what I had decided. Yeah, I didn’t feel pressured, because they gave me that option. (Participant).

Introductions. The importance of adequate introductions was reiterated several times. This is the process of mihi, which is where the welcome is inclusive of whanaungatanga. One interviewee shared her dislike of having multiple people at her bedside. Her experience involved a lack of introduction from medical students as they entered her room, and she described feeling vulnerable as her privacy was being breached.

There will be three or four of them coming in, you know, youngsters. But if they don’t ask, I tell them to go. They have to have respect, don’t they? Like I have to respect their kaupapa so they should respect me as a person too. (Participant).
In addition, participants described the experience of being called by the doctor from the waiting room as sterile and sometimes disrespectful.

"They call the patient and then they start walking away from the patient already! They start walking towards the door. They don’t say who they are. ... It’s like you’re just a number." (Participant).

The participants stated that they would be happy with some introduction and some explanation as to who the HCP was and what was about to happen. Furthermore, one participant asked if healthcare staff were allowed to shake hands.

"Everyone should shake hands! If I was a doctor, I would call them up and I would smile, I would wait for them to get as close as possible to me, and then I would introduce myself to the person, right there. Then I’d start walking with them." (Participant).

It was clear that this first interaction played a significant role in setting the tone of the rest of the consultation. They explained that a warm introduction made them feel important and respected, especially after waiting for a long period of time. One participant stated that without this interaction, Māori people might be more inclined to hold back. The participants acknowledged that the time-pressured nature of ED makes it difficult to establish long introductions, so they stated that they would be happy with a “simple hello, my name is. And come with me.”

Furthermore, participants explained that introductions allowed them to engage with the HCP on a spiritual level. One interviewee used an analogy to explain the importance of introductions and handshakes. She compared the importance of understanding whakapapa with a stethoscope.

"The stethoscope informs the person about what’s going on. What they can hear. For Māori people, a handshake is a stethoscope for us. We are informed directly through spiritual link and an innate knowingness about who we’re talking with and what environment we’re in. It’s our expression of acknowledging the person that we’re with." (Participant).

**Continued Māori cultural training for healthcare professionals.** Some interviewees recommended compulsory Māori cultural training for HCPs. They stated that regular engagement with Māori culture will help HCPs understand the Māori view of health and wellbeing and will help achieve better practice. They suggested spending time in a marae and witnessing what happens there.

"They should be exposed to that environment at least once a year. Get a see into why we do what we do. It will inform their practices, it really will." (Participant).
Because you’re not just a doctor, you’re going to be a doctor that can engage with a cultural identity. And that means that even if you get the smallest glimpse of that, you have an opening to their world. That’s really huge! (Participant).

Unique Factors for the Kaumātua

The interviewees highlighted particular barriers that affect the kaumātua. One interviewee stated that her elderly father would wait until his medical condition was severe before presenting to ED. The waiting involved in ED may be a greater hindrance for kaumātua, discouraging them from seeking care. In addition, the act of doing medical observations, for example, blood pressure and temperature recording, publicly in the waiting room was perceived as even more offensive for kaumātua. The importance of sensitive care for elderly patients was further reiterated in the context of introductions.

Don’t call out to them and walk away. Some of them need actual physical assurance, they need the doctor to be still. They need to be clear from their body language. What’s not clear for Māori people is, and even worse for older people, is if you call their name and then you walk off. Because they don’t actually know what’s being said. (Participant).

One interviewee gave another example where an elderly person was unable to use their nebulizer after being given a written explanation by a HCP. The interviewees stated that elderly people would have a better grasp if they had visual tools or were shown how to use it.

Like a card with information on it, they’ll look at that and throw it away. Too much writing! Because the older people are a bit more visual. More hands on. (Participant).

Furthermore, language is more likely to be a barrier for kaumātua. One participant suggested that having a Māori cultural support person present and acting as an advocate might ease this situation.

Limitations

This study has a limited sample size of four participants and therefore the themes outlined should be cautiously applied to other settings. In addition, all the participants were women and therefore the themes identified may not be applicable to men. Whilst this study attempted to recruit men, it proved difficult. Finding ways to engage men in these types of studies is important to get a more diverse picture of Māori health experiences. Finally, being an interviewer from a different cultural background made it challenging to fully interpret Māori culture, although the collaboration with the hospital’s Māori health department made it easier to understand some concepts and ideas.

Discussion

Some of the themes in this study have been identified in previous literature. For example, the unfamiliarity of the hospital environment can be a source of great discomfort for Māori (Wilson &
Barton, 2012). Māori recognise the hospital environment they are entering is dominated by Western biomedical constructs of health and hence do not always cater to spiritual and mental healing (Wilson & Barton, 2012). Conflicts between these perspectives of health have been found in other studies (Dew et al., 2015). One participant with cancer voiced her distrust of the Western medical system as she found it to belittle Māori interpretations of health (Dew et al., 2015). This conflict seems to arise where there is perceived disregard for Māori views on health and a refusal to use a collaborative approach. An appreciation of the Māori worldview would be empowering and help facilitate mutual respect.

The importance of whānau has arisen on multiple occasions in literature and is believed to be an important aspect of health (Ministry of Health, 2014). It is perceived as a support base when someone is ill in ED (Dew et al., 2015; Jansen et al., 2008; Wilson & Barton, 2012). Reciting karakia together was seen as an important part of healing in cancer (Dew et al., 2015). Furthermore, Jansen et al. (2008) highlighted that having many members of whānau accompanying a patient often resulted in judgement and disrespect from some HCPs. Disrespect from HCPs could cause whakamā, a major barrier for Māori, and could lead to patients leaving hospital prematurely and hinder usage of healthcare in the future (Jansen et al., 2008; Walker et al., 2017; Wilson & Barton, 2012).

In addition, it is important to note that the significant presence of whānau may result in some tensions. For example, the study conducted by Dew et al. (2015) included a participant who stated that it is difficult to disagree with whānau. This corroborates a perspective found in this study when an interviewee stated that “whānau can wait” and that sometimes the worst people an individual can confide in are their whānau. Striking a balance between allowing whānau to be present in healthcare decision making and giving solely individualised patient care may be challenging and depends on the preference of a given individual, but it is important to acknowledge and respect that Māori patients may choose to operate as a familial unit (Dew et al., 2015; Walker et al., 2017).

Another theme that has been identified in literature is the disadvantage of long waiting times (Jansen et al., 2008). Hui participants stated that they were sometimes confused as to why they had to wait for such long periods of time and wished to know why that was and when they would be seen (Jansen et al., 2008). This may be challenging to address in ED; however, better communication in the waiting room may ease this dissatisfaction. For example, reception staff could provide more announcements with regards to waiting time and show compassion to those who are frustrated and prepared to leave. Better communication in this context also plays a role in protecting patient safety as it stops those who require urgent hospital care from leaving and prevents further deterioration of their physical health.

Inadequacy of introductions by HCPs has been cited as an issue in other studies (Jansen et al., 2008; Walker et al., 2017). One participant stated that they “went through the hospital system just like I was a box, or a letter with a stamp on” (Jansen et al., 2008, p. 50). This perspective resembled what an interviewee said in this study when she reflected on doctors calling her from the waiting room as if she
were just a number. Lack of personal acknowledgement is perceived as disrespectful and may hinder communication in the medical setting (Jansen et al., 2008; Walker et al., 2017). In addition, if participants felt they were not being listened to, they would “clam up” (Jansen et al., 2008, p. 52). In this study, the interviewees reiterated this, stating that they would hold back information if they felt the doctor did not have time for them and would not establish a meaningful connection, which is the backbone of the doctor-patient relationship (Jansen et al., 2008; Walker et al., 2017). Similar to this study, Dew et al. (2015) identified that the presence of medical students at a patient’s bedside without adequate introductions was disconcerting and evoked a feeling of whakamā.

One participant recounted his anger with a doctor entering his room with medical students and talking about him without his permission (Dew et al., 2015). Furthermore, breaching privacy in this manner can leave Māori patients feeling vulnerable. Another participant in the study by Dew et al. (2015) stated that she felt embarrassed having to discuss her medical needs in the reception area and felt it was an unnecessary breach of privacy. Comments regarding the lack of distinction between public and private spaces also emerged in our study. The importance of the environment is acknowledged in The Guide to He Korowai Oranga: Māori Health Strategy, which identifies the three elements of good health: healthy individuals (mauri ora), healthy families (whānau ora), and healthy environments (wai ora) (Ministry of Health, 2014). Wai ora highlights the impact of the external environment on health and wellbeing and states that an environment should be optimised to sustain healthy life. With this concept in mind, the ED environment may need to be adapted to ensure it feels safe.

Finally, the use of Māori language in ED was appreciated by one of the interviewees in this study when she stated that seeing the Māori word next to an English word felt more inclusive. Another study identified that an appreciation of Te Reo Māori (Māori language) should be encouraged in the medical setting (Pitama, Ahuriri-Driscoll, Huria, Lacey, & Robertson, 2011). The researchers found in general practice that patients would expect doctors to know or understand the words they were using or politely seek clarification. If doctors failed to acknowledge or show interest in Te Reo Māori, they would perceive this as the doctor not wanting to build a rapport with them, which led to them disengaging with the healthcare system for some time (Pitama et al., 2011).

In addition, Pitama et al. (2011) found that mispronunciation of names early on in a patient’s journey, for example in the reception area, led to patients feeling belittled or unwelcome in clinic later on. Therefore, an appreciation of Māori names and Te Reo Māori from the onset of the patient journey can prevent this potential barrier to healthcare access. As stated by participants in this study, if HCPs take an interest in Māori culture, the relationship between doctors and Māori patients may be strengthened. This is because Māori make connections with new people on the basis of understanding of an individual’s origin and identity (whakapapa), and doing so begins with adequate introductions and taking an interest in someone’s name.
Table 3 summarises our recommendations for ED staff based on our results.

**Table 3**

*Recommendations for Emergency Departments (EDs) Based on the Results from the Thematic Analysis*

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<tr>
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<th>Recommendation</th>
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<tr>
<td>1</td>
<td>Make proper introductions in ED, including a handshake.</td>
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<td>2</td>
<td>With compassion, acknowledge long wait times and encourage patients to wait.</td>
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<tr>
<td>3</td>
<td>Ask a patient’s preference with regards to whānau being present in decision making.</td>
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<tr>
<td>4</td>
<td>Offer the service of a Māori cultural support person, especially for kaumātua.</td>
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<tr>
<td>5</td>
<td>Make the public and private spaces in ED more distinct and respect the privacy of individuals, particularly when doing medical observations.</td>
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<td>6</td>
<td>Appreciate Māori intuition about their own body and health and encourage shared decision making.</td>
</tr>
<tr>
<td>7</td>
<td>Introduce compulsory Māori health training for healthcare professionals with annual refreshers.</td>
</tr>
<tr>
<td>8</td>
<td>Continue to incorporate Te Reo Māori in the medical setting, striving to pronounce Māori names correctly and checking pronunciation in a sensitive manner.</td>
</tr>
</tbody>
</table>

**Conclusion**

In conclusion, participants largely reported satisfaction with this district health facility’s ED, highlighting positives such as the proactive nature of nursing staff and the knowledgeable and empowering approach of doctors. This study has highlighted the impact of the ED environment and interactions with HCPs on Māori experiences and has found that special care must be taken when treating the kaumātua. Service provision is improved when the health system and HCPs recognise what is important to Māori people and take appropriate steps to widen their knowledge.

**References**


