

KAUPAPA MĀORI RESEARCH AND PĀKEHĀ SOCIAL SCIENCE: EPISTEMOLOGICAL TENSIONS IN A STUDY OF MĀORI HEALTH

*Fiona Cram, Tim McCreanor, Linda Tuhiwai Smith, Ray Nairn,
and Wayne Johnstone*

In Aotearoa New Zealand, Māori research capability has grown to the point at which *Kaupapa Māori* (“by Māori, for Māori”) research is a reality. However, there are situations in which health disparities between Māori and *Pākehā* (New Zealanders of European descent) can be better understood through innovative research collaborations that examine the contributions of both cultures to Māori health issues. In the *cooperative independence* approach described here, Māori and *Pākehā* research teams think of themselves as “parties” to research about Māori patient and *Pākehā* primary care physician conceptions of Māori health. The research relationship was both satisfying and productive. The findings highlight the cultural gulf between *Pākehā* physicians and Māori clients, suggesting the need for cultural competency training for physicians.

CORRESPONDENCE MAY BE SENT TO:

Fiona Cram, Katoa Ltd.

21 Reuben Avenue, Brooklyn, Wellington, Aotearoa New Zealand

Email: fonac@katoa.net.nz

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Ko koe ki tena, ko ahau ki tenei kiwai o te kete
You at that and I at this handle of the basket

In this article we focus on the processes involved in a bicultural research project (hereafter the physician project), funded by the Health Research Council of New Zealand, in which independent but collaborating *Māori*¹ and *Pākehā*² research teams investigated the ways in which Māori users of primary health care services and Pākehā physicians talk about Māori health and their experiences with each other in health encounters. The aim of this research project was to investigate the discursive practices at play in this domain of intercultural relations to understand any impacts they may have on the persistent health disparities between Māori and Pākehā.

Alongside a description of the study itself, we present a methodological analysis of our own research process as a reflexive commentary on the epistemological tensions inherent in research across power differentials, and as a contribution to some unanswered challenges presented by Pākehā and Māori researchers undertaking health research of interest to Māori. The purpose of this approach is to illuminate the epistemological, theoretical, and political commitments that Māori and Pākehā researchers brought to the project. As such, the article relates to established critical traditions that count reflexivity, awareness, and sensitivity to the place of the researcher in knowledge creation as important issues in validating and interpreting research findings (L. T. Smith, 1999; Wetherell, Taylor, & Yates, 2001). An additional goal of this article is to stimulate methodological and political debates on models of Māori–Pākehā research relations in the social sciences in Aotearoa New Zealand and to add to conversations about indigenous–nonindigenous research relations in the social sciences globally.

As the research capacity of indigenous groups continues to increase, there will be a growing need for such challenges to current notions of research relations. In Hawai‘i, programs such as ‘Imi Hale–Native Hawaiian Cancer Network are striving to build Native Hawaiian health research capacity (Tsark & Braun, 2004). Some of the reflections in this article may well connect with the experience of Native Hawaiian health researchers on two fronts: the creation of research collaborations with nonindigenous researchers and the examination of health care encounters between indigenous patients and nonindigenous physicians.

MĀORI HEALTH DISPARITIES

The starting point for our research was the sharpening of our general knowledge about Māori health. The health disparities between Māori and Pākehā populations within Aotearoa New Zealand are well documented (Howden-Chapman & Tobias, 2000; Pōmare et al., 1995). Māori have poorer outcomes across a wide range of health statistics, and this disparity has been reflected in official statistics for many decades (e.g., Turbott, 1940). The gap may have been reduced over the decades of the 20th century, but it still remains. Māori health researchers argue that the governmental reforms of the late 1980s and early 1990s led to an increase in the disparity (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003; Pōmare et al., 1995).

Health disparities between indigenous and nonindigenous peoples are an enduring legacy of colonization (Smylie, 2005). In the 1990s, Native Hawaiians had the lowest life expectancy in the United States and suffered disparate rates of heart disease, cancer, and diabetes. Within a dominating culture of biomedicine, a commonly held view is that Native Hawaiians are innately unhealthy (Blaisdell, 1998; McMullin, 2005). This is not dissimilar to Pākehā representations of Māori (McCreanor & Nairn, 2002a, 2002b).

Common Pākehā representations of Māori health, based on the reductionist biomedical model, facilitate blaming Māori, or sometimes Māori culture, for the current state of affairs. In such talk Māori are represented as ignorant, shy, superstitious, or backward (Beaglehole & Beaglehole, 1946). Historically, the Pākehā response based on such constructions has been manifest in attacks on traditional Māori medical practices or efforts to “educate” Māori people (Simon & Smith, 2001). In the early decades of the 20th century, health workers persuaded Māori mothers not to breastfeed or, alternatively, to boil their breast milk to reduce tuberculosis. Turbott’s (1940) account of typhoid among Māori is another example, stressing the need for “education...to develop the desire for improved hygiene and better homes” (p. 247). A more recent example of the process of blaming cultural practices was found in the discussions of cot death. The published prevention strategies in the 1990s led to marked reductions in the deaths of Pākehā babies, while death rates among Māori babies remained virtually unchanged (Public Health Commission, 1993). Faced with this failure, some authorities attempted to pin Māori rates to bed-sharing (see, e.g., “Coroner has Warning,” 1993). Blaming Māori for their own ill-health serves to avoid consideration of the impacts of Pākehā systems, ideologies, and practices (i.e., the entire colonial process) on the issue.

General Māori conceptions of health, on the other hand, are known from a number of written descriptions identifying integrated, holistic, community-based concepts that differ fundamentally from the standard Pākehā approach (e.g., Pere, 1988). In this way, Māori conceptions of health are close to those of Native Hawaiians (e.g., Mayberry, Affonso, Shibuya, & Clemmens, 1998; McMullin, 2005). Māori conceptions of health tend to cohere around resilient cultural concepts and practices, such as the relationship between *tinana* (body) and *wairua* (spiritual essence), the concepts of *tapu* (sacred) and *noa* (ordinary), and the ritual of *tangi* (mourning), to name a few (Dansey, 1992; Marsden, 1992). These representations promote holistic, integrated practices based on self-sufficiency and Māori empirical knowledge about health and healing. They include diet, exercise, herbal and traditional medicines, the use of *karakia* (prayer), *whānau* (family) involvement, and other practices that have been frequently criticized, undermined, and sometimes outlawed by the dominant Pākehā views on health.

In the past 20 years, Māori views of health have crystallized older, cultural understandings, to conceptualize a holistic schema encompassing *tinana* (the physical element), *hinengaro* (the mental state), *wairua* (the spirit), and *whānau* (the immediate and wider family) within the health area (Murchie, 1984). Also known as the *Whare Tapa Wha*, or four cornerposts (Durie, 1994), these aspects occur in the context of *Te Whenua* (land providing a sense of identity and belonging), *Te Reo* (the language of communication), *Te Ao Turoa* (environment), and *Whanaungatanga* (extended family relationships; see Public Health Commission, 1993, p. 24). The disruption of such theoretical structures and the practices they sustain, by Pākehā ideologies of health in the course of the colonial process, means it is unclear if and how these ideologies are active among Māori in the contemporary setting. The Māori section of the physician project sought to discover if any of these resources are used in the talk of Māori participants in constructing Māori health.

Māori also report understandings about Pākehā health care that are the legacy of past experiences between Māori clients and Pākehā health professionals. These include suspicions about treatment, the reluctance to engage in an interaction with health professionals, and behavior referred to in the sociological literature as resistance (L. T. Smith, 1985). Such actions have been interpreted by some as evidence of *whakamā*, the notion of shame or shyness (Metge, 1986), but they may also be part of a more general reaction to being treated in patronizing or paternalistic ways (Awatere, 1984). Consideration of this last point, alongside historical accounts

of Māori good health prior to European incursion into the country, made us less inclined to accept the victim-blaming conclusions of individualizing biomedicine as a satisfactory explanation of Māori health disparities. Instead, we wanted to look at what the medical system could be contributing to the situation. We knew that Māori utilization of primary health care services was different in nature, if not in level, to that of Pākehā (McAvoy, Davis, Raymont, & Gribben, 1994). Māori were shown to present later and with more florid symptoms, suggesting a nonspecific discomfort with the medical system. If there were problems, would we be able to shed light on them in the Pākehā section of the physician project by talking to medical practitioners who, after all, are the empowered, authorized parties to this interface between Māori and Pākehā? It was with this question in mind that we turned our attention to primary health care in Aotearoa New Zealand.

PRIMARY HEALTH CARE

Māori seeking primary medical care will invariably end up in the consulting rooms of Pākehā physicians, because the number of Māori physicians is small. The consulting room can be viewed as a site of struggle between Māori patients and Pākehā physicians. The struggle occurs because of the meeting of two different kinds of “lived ideologies,” namely, Pākehā and Māori. It is a struggle over power and over whose ideology informs and controls the interaction. Within this context, the interaction between Māori patient and Pākehā physician becomes more than just getting along well and communicating on an interpersonal level; it is also about negotiating cultural boundaries. The central focus of our study is how both parties that engage in these interactions—Māori as patients and Pākehā as physicians—talk about Māori health and their experiences of interacting with one another.

The literature (Silverman, 1987; Simpson et al., 1991) points out that the quality of such talk has profound impacts—even on apparently physical symptoms such as blood pressure—and is of crucial importance in psychosocial and psychiatric problems. Communication is also strongly implicated in treatment compliance in chronic diseases such as diabetes (Kaplan, Greenfield, & Ware, 1989). In this

vein, one prominent study (Mishler, 1984) has taken a discourse analytic approach focused primarily on the diagnostic interview, highlighting the material impacts of such specific discourse. Although doctor–patient communication is an important facet of our concerns in this project (and a likely subject for detailed investigation beyond it), we were keen to cast the net wider to draw in other features of discourse that constitute a more general context to Māori health. As previously outlined, history (both personal and sociopolitical), relations of dominance and oppression, worldview and spirituality, are all expected to influence constructions of health analyzed in this study.

The second strand of this project story, a reflexive commentary that weaves in and out of our team discussions of the research topic, began with our deliberation of who should conduct Māori health research.

WHO SHOULD DO MĀORI HEALTH RESEARCH?

In many fields of social science research, including health—where researchers are conducting investigations with groups who are comparatively disadvantaged or marginalized—it is recommended that research partnerships be formed to reduce the perceived distance between those doing the research and those being researched. Such arrangements are described as a vehicle through which researchers, their work, and the knowledge produced can be more “useful” to participant communities (Moewaka Barnes, 2000). For example, in the Australian context, Humphery (2001) highlighted calls for indigenous involvement in the direction and conduct of research important to indigenous communities. Furthermore, First Nations peoples in Canada have called for research to be decolonized (Ten Fingers, 2005), and in Hawai‘i, moves are afoot to firmly recenter Native Hawaiians within research and evaluation with indigenous communities (Cook, 2001; Kahakalau, 2004).

In Aotearoa New Zealand, where the indigenous Māori have been displaced and dispossessed in the course of 160 years of Pākehā colonization, guidelines for Pākehā researchers wanting to research Māori health issues urge the establishment of collaborative research approaches and partnerships. Ethics guidelines within some disciplines have also been formulated with the notion of

partnership between non-Māori researchers and Māori research communities in mind (e.g., Te Awekotuku, 1991). These initiatives are to be admired because they have prompted all researchers to question their practice and, indeed, their view of the world, so that in our situation there is emerging consensus that research should be at least culturally sensitive, if not fully vested with the provisions of cultural safety (Ramsden, 1997). However, such moves are premised on a shortfall in Māori research capacity that requires non-Māori researchers to conduct Māori research. This shortfall is less and less likely as Māori research capacity is growing rapidly. As such, the guidance offered to researchers does not fully explore the issues faced by Māori researchers who are conducting research with Māori. This is not a situation of researchers researching “down”; rather these researchers must negotiate the multiple and often subtle ways in which they are both an insider and an outsider to their participant group (L. T. Smith, 1999).

In addition, the guidelines on partnership research do not speak to Pākehā researchers who want to do research “for” Māori that is not necessarily research “with” or “on” Māori; in other words, Pākehā researchers who want their research to support a Māori epistemological framework through the development of a research-based critique of Pākehā theories, policies, and practices, especially as they relate to Māori–Pākehā relations. In response to the first of these gaps, L. T. Smith (1999) outlined seven ethical principles that are relevant for Māori research. Cram (2001) expanded these principles in general research guidelines for Māori researchers (see Table 1). The second issue of Pākehā researchers supporting a Māori *kaupapa* (framework) remains largely unaddressed (Cram & McCreanor, 1993; Huygens, 1993). In seeking guidance on this issue, we turned to the founding document of Aotearoa New Zealand: *Te Tiriti o Waitangi* (The Treaty of Waitangi; Orange, 1987).

TABLE 1 “Community-Up” approach to defining research conduct

Cultural values (L. T. Smith, 1999)	Researcher guidelines (Cram, 2001)
Aroha ki te tangata	A respect for people; allow people to define their own space and meet on their own terms.
He kanohi kitea	It is important to meet people face to face and to also be a face that is known to and seen within a community.
Titiro, whakarongo... kōrero	Looking and listening (and then maybe speaking); develop understanding in order to find a place from which to speak.
Manaaki ki te tangata	Sharing, hosting, being generous.
Kia tupato	Be cautious; be politically astute, culturally safe, and reflective about insider/outsider status.
Kaua e takahia te mana o te tangata	Do not trample on the “mana” or dignity of a person.
Kia mahaki	Be humble; do not flaunt your knowledge; find ways of sharing it.

Note: From “Researching in the Margins: Issues for Māori Researchers—A Discussion Paper,” by L.T. Smith, 2006, *AlterNative: An International Journal of Indigenous Scholarship*, (Special Supplement 2006–Marginalisation), pp. 4–27. Copyright 2006 by Ngā Pae o te Māramatanga.

The treaty was first signed at Waitangi on February 6, 1840, by Māori chiefs and British officials. It paved the way for British settlement in Aotearoa New Zealand while at the same time guaranteeing social and economic rights and privileges to Māori (McCreanor, 1989). The principal right guaranteed to Māori was *tino rangatiratanga*, which denotes not only possession but also control and management of lands, dwelling places, and other possessions (Waitangi Tribunal, 1983). However, disputes over the treaty have occurred because of differences between the English and Māori versions of the treaty. In the English text Māori cede “sovereignty” to the Queen, whereas in the Māori version they cede only *kawanatanga*, the right to govern.

Controversy and debate still surround the role of the treaty in Aotearoa New Zealand society, but it has certainly come to the forefront of current-day discussions about Māori–Pākehā relations and Māori aspirations for self-determination (Dyck & Kearns, 1995; Jackson, 2004). It therefore stands to reason that the treaty should also be considered central to a discussion of research conducted within this

country. It was tempting to use the common terminology in Aotearoa New Zealand of treaty “partnership” and apply this to the relationship between the Māori and Pākehā research teams. However, we were wary of treading the negative pathways that have come to be associated with the term partnership (Torjman, 1998). It is too easy to conceal important power differentials beneath the egalitarian gloss of partnership, a factor widely experienced in bureaucratic responses to Pākehā treaty responsibilities.

Instead, we prefer to define partnership as a goal rather than as an existing state. We have therefore chosen to base our thinking within an analysis that views Māori and Pākehā as parties to the Treaty of Waitangi, and we have applied this terminology to our research relationships. Both parties to the research therefore have a stake in it and have consequent rights and responsibilities. These rights and responsibilities were to be negotiated between parties throughout the project.³ Being “parties to a research project” is also terminology that can apply more generally to indigenous–nonindigenous research collaborations, even in the absence of an overarching treaty. The following section describes one such research collaboration.

THE PRESENT PROJECT

The present project examined how two groups of participants, Māori patients and Pākehā physicians, talk about Māori health. These speakers constitute a given entity such as Māori health in differing ways, depending on their understanding of the context in which they are speaking. To do this, they must draw on an array of resources provided within their community. These resources are the object of this study. For this project, it means we do not seek to provide a definitive representation of the single coherent entity, “Māori health,” but to identify the resources two distinct groups of informants use in constituting the entity in their talk. We felt that if we could describe these resources—and particularly, if we could understand critical differences between them—then we would be in a position to inform and encourage action in both groups to improve outcomes. A critical element of the present project was the relationship between the two research teams, with the Pākehā research team taking responsibility for examining the talk of Pākehā physicians and the Māori research team taking responsibility for talking with Māori patients.

Methodology

By methodology, we mean the theoretical approach that determines the way we undertake research, including, for example, our relationship with participants and the communities where we work and live. Methods, on the other hand, are tools that can be used to produce and analyze data, for example, in-depth interviewing and questionnaires (L. T. Smith, 1999). The methodology for the present research is sourced in *Kaupapa Māori* (“by Māori, for Māori”) theory. *Kaupapa Māori* research is an attempt to retrieve space for Māori voices and perspectives, methodologies, and analyses, whereby Māori realities are seen as legitimate. This means working outside the binary opposition of Māori and Pākehā and centering *Te Ao Māori* (the Māori world; see Pihama, 1993).

Kaupapa Māori takes for granted the legitimacy of being Māori and the validity of Māori worldviews. Māori language and culture are therefore seen as central. In addition, *Kaupapa Māori* acknowledges, and is underpinned by, Māori struggles for autonomy and self-determination (G. H. Smith, 1997). An integral part of *Kaupapa Māori* theory is also the critique of societal “common sense” understandings of what it is to be Māori. These understandings have invariably been built up over decades of colonization, are based on deficit models, and provide justifications for policies and practices that oppress Māori (Pihama, 1993).

Within *Kaupapa Māori* research, the role of researchers is therefore twofold. First, researchers need to affirm the importance of Māori self-definitions and self-valuations. Second, researchers need to critique Pākehā/colonial constructions and definitions of Māori and articulate solutions to Māori concerns in terms of Māori knowledge. Linda Smith (1999) argued that while Pākehā researchers cannot do *Kaupapa Māori* research, they can support Māori *Kaupapa* (also see Cram, 1997). Our research discussions of these issues have also rested on the premise that Pākehā researchers would not be doing research with Māori participants but would be doing research that would be of benefit (or at least relevance) to Māori. Nevertheless, a joint approach was valuable because of our conception that the “problem of Māori health” was at least as much a Pākehā problem as (if not more than) a Māori problem. By this we mean that there are significant contributions to Māori health from both Māori and Pākehā, given the Pākehā domination in the process of colonization and alienation of Māori resources, not to mention the long-standing theoretical and applied domination of health theory, practices, and services.

In seeking to understand the disparities between the goals of both health authorities and consumer groups and the outcomes described in the reports, the research project focuses on the construction of Māori health in the talk of physicians and Māori clients. To appreciate the value of such work, it is necessary to recognize the links between such discourse and the social practices of those for whom these representations constitute “reality.” There is a substantial body of research demonstrating that the way in which people, as individuals or groups, define reality is a major determinant of their behavior. In problem solving (Johnson-Laird, 1983), interpersonal behavior (Snyder, 1984), among scientists (Gilbert & Mulkay, 1984), and in the community (Potter & Reicher, 1987), the way in which situations or events are understood has been shown to shape participants’ actions.

Recent developments in social science have inspired a growing body of language-based research in areas of social dominance and inequality (van Dijk, 1993; Wetherell & Potter, 1992; Wetherell et al., 2001). There are two assumptions underlying this work that must be understood if the power of its findings is to be appreciated. First, it is assumed that the reality of objects, events, and situations is constituted through the discourses about them. The second assumption is that the way in which the reality of a particular object, event, or situation is constituted depends on the interest or concern of the speaking individual in that situation. It follows from the first assumption that research in this tradition does not seek to uncover or define the essential nature of the targeted entity; indeed, it assumes that such a description would be merely another way of constituting the object. In doing so, research introduces the realm of power relations into knowledge-based enterprises, to make explicit the ways in which differentials in material and political power are manifest in material differences in the situations of differently empowered groups. In this context, the ideologies of those with power will be dominant over those of people who have less.

Theories of ideology (Bordieu & Passeron, 1990) emphasize the role of language in the reproduction of ideology and the importance of the latter to the establishment and maintenance of social relations. However, in its conventional context of class struggle, ideology is characterized as the tool of ruling elites and is evoked to explain the control of the masses. We are more interested in the formulation by Billig et al. (1988), which presents the idea of *lived ideology*—the array of ideas, beliefs, and explanations drawn on to interpret everyday experience.

For the Pākehā research team, the poststructuralist perspective that has encompassed the critique of empiricism has also inspired the development of qualitative research styles focused on the explication of language in areas of gender (Gavey, 1989; Lather, 1991) and cultural relations (Essed, 1988; Nairn & McCreanor, 1990). Methods built around the discourse analysis of transcriptions of semistructured interviews (Potter & Wetherell, 1987) offer detailed understandings of the complexity and dynamics of intergroup relations that are lost in the traditional social science approaches of experiment and questionnaire.

For the Māori research team, this perspective offered one tool for the analysis of Māori talk. Māori theories of knowledge encompass empirical traditions for enumeration, measurement, and comparison, yet the historical storage, retrieval, and transmission of knowledge through oral culture means that there is an ongoing orientation toward talk as data. The everyday understanding of knowledge as constructed/enacted is cemented in the institutions and practices of Māori societies, such as *whakapapa* (genealogy), *waiata* (song), and many others. While these practices are continually undermined and derogated through the colonial imposition of Western worldview, culture, and science, the renaissance in Māori society at large has seen the resurgence of interest in discourse, reclaiming testimony, life story, and storytelling as legitimate forms of knowledge (L. T. Smith, 1999). In this project, the research interviews incorporate many of these elements, providing a particularly rich and deep base of experiential material from which to draw the themes and patterns, as well as the variations in participants' encounters with primary health care in keeping with the imperatives of the chosen research question.

Potter and Wetherell (1987) argued that approaching such data as a topic of study "in their own right" is theoretically justified, methodologically possible, and socially significant. It is a naturalistic option that acknowledges the possibility that people are positioned within heterogeneous and contradictory discourses, and that these discourses can reflect the manner in which power relations in a field such as Māori health may be manifest. Discourse databases are designed to sample the kinds of linguistic resources available, rather than to assign individuals into preconceived categories (as do survey studies) or to provide a single, apparently coherent account of a concept such as Māori health that is variously constituted in

participants' talk and practice. This means that discourse studies typically draw on relatively small numbers of participants, whose talk centers on common topics and particular tasks such as explaining and justifying. For this reason, it is assumed that fewer individuals speaking in more depth will provide a global impression of the discursive resources available.

An array of broadly critical discursive approaches to the scientific study of social life has emerged (Wetherell et al., 2001). These include poststructuralist discourse analysis, conversation analysis, and critical discourse analysis (van Dijk, 1993), offering a comprehensive approach to the dimensions of text that need to be examined to provide rigorous descriptions of the structure and function of discourse. In addition, a theoretical rationale for critical study of the discourse of both the empowered and the disempowered, as a means of highlighting social injustice, is beginning to appear (Wodak & Matouschek, 1993). Studies of the production of dominance mainly focus on the discourse of the empowered in the enactment of their ideologies. For example, Wetherell and Potter (1992) analyzed Pākehā talk about "racial issues" and showed that speakers use a variety of discursive resources to justify the relative positions of Māori and Pākehā, to present themselves in a positive light, and to legitimate the status quo.

However, beyond the particular commitment to work toward "depowering" elites (Huygens, 1993), discourse theory also identifies a key role for the study of the discourse of the oppressed in challenging existing social relations (Essed, 1988). The notion of hegemony (Gramsci, 1971) foregrounds ways in which disciplinary power may be internalized in the ideologies of the oppressed, leading them into beliefs and practices that entrench their condition (Awatere, 1984). Knowledge of the discourses of the disempowered may act as a catalyst in the political development and educational programs among oppressed groups, which in turn challenges established ideology and leads to social change.

Data and Analysis

Indigenous theories of knowledge challenge Western theory in a contest for space to determine what counts as data (L. T. Smith, 1999). There are echoes of this tension within Pākehā thinking as positivist and constructionist philosophies battle over the legitimacy of methods—and thus conceptions—as to what will count as data. The former regards data as deriving from empirical observation and experiment, whereas the latter creates new possibilities based on experience, especially as represented in discourse and talk. In the context of the larger conflict between indigenous and colonizing epistemologies, there are resonances between the constructionist and indigenous approaches to knowledge, which predispose both to orient to talk and text as data for understanding and interpreting the lived experience of population groups.

The research question is pitched in such a way that calls for qualitative data, because it bears on and illuminates the situated interpretative resources and common-sense, lived ideologies of particular communities. We wanted to know about the ways in which two interacting groups construct and interpret those interactions. Qualitative data give us the richness and depth from which to build accounts of the recurrent patterns and variations in such talk. Asking participants directly about the topic of Māori health (in which both groups have an interest) evokes the shared vocabularies, grammar, imagery, ideas, and meanings available and current in their constructions and interpretations of the topic. These data will have integrity and meaning on their own; when they are brought into “conversation” with each other, the data will potentially reveal important insights about the basis and nature of the interaction between Māori clients and Pākehā doctors.

We decided that in the first instance, as the study was exploratory and inductive, we would conduct face-to-face interviews. We wanted the data to be able to “speak from two sides” as a way of approaching the different experiences of the two groups around the common topic rather than as a basis for a simplistic compare-and-contrast exercise. For this reason, we took a flexible approach to both the form and the content of interviews gathered by the teams, being prepared for what came forth from a relatively negotiated, organic process rather than trying to dictate uniformity for comparability.

Māori Participant Interviews

While the Māori side of the physician project chose individual interviews, there was a flexibility that was sensitive to a preference enacted in some instances of participants contributing in pairs rather than alone. Twenty-eight Māori participants (ages 17 to 74) were interviewed. The interviews were loosely structured to allow the participants to be in the driver's seat regarding the direction the interviews took, areas that were open to discussion, and the length of the interviews. Participants were invited to talk about Māori health and to tell their stories about interacting with non-Māori physicians. We would be hesitant to call our method “talk story,” but we definitely have an affinity for this as a way of engaging with research participants. The interviews were fully transcribed, and the transcripts formed the data for a thematic analysis.

Pākehā Participant Interviews

While Pākehā researchers have had to struggle to establish the legitimacy of qualitative methods in general—and discursive approaches in particular—within these emerging traditions there is a central concern with talk and text as data. In the case of the Pākehā doctors, we decided to pursue individual interviews for pragmatic reasons, because our connections indicated that getting doctors together in groups would be more difficult owing to their busy schedules. We felt clear that following the lead of Wetherell and Potter (1992), this would be the preferred mode of contribution to the project for this group. In addition, it seemed that it might be easier to manage any power dynamics one to one, rather than with a group of relatively assertive and articulate individuals.

Twenty-six physicians were interviewed. For the purpose of data that can be used to identify interpretative repertoires, individual interviews are assumed to involve the participant in the articulation of common forms of talk, without the complicating factors of interactive phases with coparticipants. While it is true that the interviewer—to a greater or lesser extent—coconstructs the interview, in this instance the interviewer (Tim McCreanor) was relatively unfamiliar with the topic. Further, with participants speaking from a position of strength, we were confident there would be clear articulations of the resources available to physicians to talk about Māori health.

FINDINGS

To date, there have been three publications from this study. The first, which is primarily methodological, appeared in the *Journal of Health Psychology* (McCreanor & Nairn, 2002a), whereas the second and third articles reporting overviews of the Māori and Pākehā findings appeared separately in the *New Zealand Medical Journal* (Cram, Smith, & Johnstone, 2003; McCreanor & Nairn, 2002b). The latter articles report widely divergent themes from discursive analyses of data gathered from Māori and Pākehā participants. Further publications will elaborate these differences and consider the implications for equitable and realistic policies for health service delivery in a colonial situation with entrenched health disparities between Māori and Pākehā.

The findings represent a contribution to a social analysis of medicine in Aotearoa New Zealand that has historical dimensions (Nicholson, 1988) and contemporary components (Westbrooke, Baxter, & Hogan, 2001). The findings also demonstrate similarities with the widely available critique of racism in health, which fuels ethnic health disparities worldwide (Karlson & Nazroo, 2003; Krieger, 2003). Māori and Pākehā have very different ways of constructing and talking about health, which arguably play out in primary health care consultations and have real impacts on the health of Māori individuals, communities, and populations.

Māori Patients

This section provides an overview of 5 of the 10 recurrent themes that arose from the interviews with Māori patients. (See Cram et al., 2003, for a full overview.)

MĀORI HEALTH. When answering the question “What is Māori health?” many of the participants emphasized the importance of defining health holistically. They acknowledged both the interconnectedness and the importance of balance among the physical, mental, and spiritual aspects of health. The significance of whānau or family (see below) was also stressed. Some participants also talked about the impact of social and economic well-being on Māori health, the disparities between Māori and Pākehā health, and the role of Māori health care provisions in maintaining health.

TRADITIONAL WAYS. The holistic, relational nature of Māori health was closely linked to participants' discussion of traditional Māori approaches to, and knowledge about, healing. Many of the participants had engaged in traditional healing practices related to, for example, *rongoā* and *wairua* (see below). These practices therefore continue to have a role in Māori health.

RONGOĀ. Rongoā includes remedies, therapies, and spiritual healing. Older participants told stories from their youth about rongoā being used in times of illness. Rongoā were also currently being used by both young and old participants who saw this as compatible with their use of Western medicines. Two of the *kuia* (older women) spoke about their own specialized knowledge of rongoā and of sharing this knowledge with others.

WAIRUA. Wairua, or spirit, was the most commonly mentioned element of Māori health. It was seen by participants as key to understanding health and illness as it provides insight into the whole person, not just the person's manifest symptoms. Without such insight, healing cannot occur as a person's physical or mental symptoms may well have other, underlying causes. This understanding was seen as being fundamental in Māori health practitioners, whereas Pākehā practitioners were seen as less likely to understand it, often treating only the symptoms.

WHĀNAU. Participants spoke about the whānau, or family, as the foundational structure for Māori. Whānau buffers its members from the wider world, including experiences of illness, treatment, and hospitalization, and is therefore integral to Māori health and well-being. Participants were in agreement about the importance of the leadership roles *kuia* and *koroua* (older men) have within whānau. It was also acknowledged that some whānau did not function in this way because of family stresses (e.g., economic, social). These whānau were seen as coping the best they could and in need of both relief and hope.

Pākehā Physicians

In this section, we outline 5 of the 10 repertoires that emerged through our analyses of the data. These sketches are summaries of more lengthy analyses (McCreanor & Nairn, 2002a, 2002b) consisting of detailed descriptions of themes illustrated by verbatim excerpts from transcripts.

MĀORI IDENTITY. The issue of who should be counted as Māori was seen as deeply problematic and was widely used as a discursive device for discounting claims of racism or cultural insensitivity. Scientific definitions based on genetics were routinely offered but regularly conflicted with social constructions of Māori identity, leaving no viable objective standard. Some participants argued there was insufficient justification for conceptual or practical differences in their work with Māori and Pākehā patients.

MĀORI MORBIDITY. In line with population data, Māori were seen as more commonly and more severely afflicted by a wide range of serious and mundane conditions. Some participants argued that Māori under their care were much better off, but most concurred there was a real problem nationwide. Explanations of these disparities were cast as interactions between genetics and environment (primarily socioeconomic status and culture) in conventional biomedical terms, with no analysis of racism or colonialism.

COMPLIANCE. Participants widely reported that one of the key issues in working with Māori was noncompliance, which meant that Māori must accept responsibilities for failures or breakdowns in health care. Compared with the rest of the practice population, Māori did not take a consistent preventative approach to their health care and were frequently locked into distressing, reactive, crisis-oriented treatment regimes, to which they had little commitment. This was said to arise from a present-focused, laissez-faire worldview, seated in ignorance, willfulness, or self-destructive tendencies that characterized the Māori approach to life in general.

STYLE OF WORKING WITH MĀORI. Despite the preemptive arguments about Māori identity, most participants reported important differences in how they would work with Māori and Pākehā patients. In particular, participants noted the need to allow more time with Māori patients to facilitate rapport-building and to allow for a more flexible unfolding of the medical history. Specific issues included protocols for physical examination, use of group consultations, indirect communication with patients (via senior women), simple presentations of information using pictures, repetition, extra input on follow-up, and flexibility with respect to punctuality and payment.

MĀORI CONCEPTIONS OF HEALTH. Many participants were clear that Māori think about health in quite different ways than do Pākehā but were able to give only a general outline of what Māori conceptions were. Very few had knowledge of formal Māori models of health; some named a few actual remedies or practices from Māori traditions and felt that acquiring such knowledge was not their responsibility or interest. A discourse about complementary medicine was drawn upon, to argue that if there was no harm done in the course of such practices, then they were to be accepted and even encouraged.

DISCUSSION

The findings from the studies are strong evidence of the cultural gulf between primary care physicians and Māori clients of these professionals. The findings highlight the different conceptualizations, practices, and expectations that inform and shape the actual interactions of primary health care. The inevitable power differential at personal, systemic, and institutional levels that exists between the groups—and in many of the clinical consultation dyads that constitute primary health care—is a likely contributor to the differential patterns of health service usage and outcomes for Māori and non-Māori.

Addressing this power differential will require more than cultural competence training in its narrow sense. Rather, change will require a broader, twofold agenda for cultural competency such as that suggested by Symonette (2004). The first component, “Inside/Out,” would require physicians to develop an understanding of power and privilege hierarchies, including how they and their patients are located within these hierarchies. The second component, “Outside/In,” would encompass the development of diversity-relevant knowledge and skills. Politically and ethically, it is incumbent on the physicians to work for change. This is not to say that Māori should not also work for change, but that a heavy responsibility lies with the empowered group. For Māori, our research is about validation and affirmation. It is one thing to suspect that the treatment you receive from your physician is affected because you are Māori; it is another thing to have those suspicions confirmed and analyzed within a broader, ideological context.

In terms of research process, we have worked together as Māori and Pākehā researchers; as parties to a historical and living agreement to cooperate, Te Tiriti o Waitangi: as parties interested in exploring specific domains such as health in pursuit of social justice in this country; and as parties with interests in social justice for indigenous peoples worldwide. The idea was that we would be apart, but talking to one another, and somewhere down the track we would come together to link up the findings emerging from the components. This has required a large element of trust, as we were simply unsure of what we were getting into. We adopted a process of routine reporting, delivered through monthly meetings on how each group was faring, supplemented by extra contacts when problems arose or significant insights emerged. “Cooperative independence” seems like a simple catchphrase to characterize this stage. Similar patterns emerged in the analytic phases as the teams worked to process their data and then to see that the approaches were sufficiently congruent to all the datasets (to speak to each other).

The development of this bicultural knowledge is firmly situated within Kaupapa Māori. On the one hand, the exploration of Māori experiences of primary care has looked inward, asking Māori to talk about their understandings of Māori health and their experiences of engagement with non-Māori physicians. On the other hand, the exploration has looked outward, asking how these same experiences are constituted within the talk of Pākehā physicians. Several key lessons from our research process are highlighted below:

- There is an important role for nonindigenous researchers who are committed to supporting indigenous research agendas. This role is about working with and alongside indigenous researchers, but not necessarily researching within indigenous communities. Rather, nonindigenous researchers can turn their gaze on nonindigenous communities in which the underlying causes of indigenous marginalization can be found and challenged. In Hawai‘i, this might mean that non-Hawaiian researchers ask systemic questions about the power and privilege that is embedded within nonindigenous institutions, and whether this power and privilege works for or against Hawaiian well-being and self-determination.

- By taking the stance of “interested parties” to the research—as distinct from research partners—we were able to keep the power relations between us, as Māori and Pākehā, clearly in the frame throughout the research process. On the whole, this encouraged a much more negotiated set of research relations in which the assumptions of either party were available for scrutiny throughout the research process. This accountability process is important. Nonindigenous researchers, for example, should not rush off to do the research they think will serve an indigenous agenda, even if this research is with nonindigenous communities. Rather, the research agenda should be negotiated with, and be accountable to, indigenous peoples. In this project, we have found that one such accountability framework occurs when indigenous and nonindigenous research teams work together.
- The intellectual traditions of both Māori and Pākehā were comfortably encompassed within the methodological framework we settled on for our investigation. In addition, the selection of research questions assumed that there would be two perspectives at play and drew on the knowledge, expectations, and agendas of both parties. The most important elements in this were our mutual respect and the commitment we each brought to the research relationship. Through this, we have put into effect many of the practices that guide Māori researchers (see Table 1), such as a respect for one another, a willingness to listen and to share expertise, and a belief that we can learn from one another. These cultural values can provide useful guidance for how indigenous and nonindigenous researchers can behave toward each other when they address an indigenous concern through joint research.
- Power differences between the two groups supplying data meant that each team took its own approach in analyzing the materials while keeping each other informed and retaining the option of further collaborations. The result was that the findings, while reflecting the very different experiences and approaches informing the discourses of the two groups on issues of Māori health, nevertheless mirror and anticipate each other in ways that have significant implications for health service delivery. The prospect of these types of synergies is real in this research model, with one outcome being multiple sites—both indigenous and nonindigenous—at which the findings might be brought to bear to facilitate social change.

This elucidation of understandings and power dynamics that influence Māori health and well-being has been one fruit of this research relationship. Change in the current lived ideology of this context now needs to follow if Māori are to be well served within primary health care in this country. We believe our experiences of collaboration have generated insights of importance to future research in Aotearoa New Zealand and, we hope, of interest to researchers in Hawai'i and elsewhere.

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ABOUT THE AUTHORS

Fiona Cram (Ngāti Kahungunu), PhD (University of Otago, Social and Developmental Psychology), is the director of a small research and evaluation company, Katoa Ltd. Her evaluation work is mostly with Māori and Iwi (tribal) organizations and social service providers. Her current research interests include Māori health, family violence prevention, organizational development, and Māori language regeneration.

Tim McCreanor, PhD, is a social science researcher with Te Ropu Whariki. His key interests are in antiracism, public health, discourse, and social justice.

Linda Tuhiwai Smith (Ngāti Porou, Ngāti Awa), PhD, is professor of education at the University of Auckland, Aotearoa New Zealand. She is joint director of Ngā Pae o te Māramatanga, the National Institute for Research Excellence in Māori Development and Advancement, hosted by the University of Auckland. She is a leading Māori and indigenous educationist whose work is recognized internationally through her 1999 book, *Decolonizing Methodologies: Research and Indigenous Peoples*.

Ray Nairn is an established social science researcher and president of the New Zealand Psychological Society. He is a longtime antiracism advocate and a worker for social justice and has recently completed his PhD on media depictions of mental illness.

Wayne Johnstone (Ngāti Wai) is project manager of Te Puna Oranga, Waikato District Health Board. Research interests include Māori health, diabetes, and indigenous peoples.

NOTES

- 1 Māori are people of Polynesian origin who have been settled in Aotearoa New Zealand for nearly a millennium.
- 2 Pākehā is a Māori word for New Zealanders of European descent.
- 3 This conceptualization is inclusive of the possibility that the relationship may be extended to other parties, such as Pacific peoples.