THE INTERSECTION OF MEDICAL TREATMENT AND MĀORI CULTURAL VALUES WITH SERIOUS HEAD-RELATED INJURIES

Gary Barclay, Richard Kerr-Bell and Simon Middlemas

PREFACE

This work is based on my (Gary Barclay) personal reflections regarding serious injury. The aim of this article is to stimulate discussion on the potential influence of cultural perspectives on the treatment of serious head-region injuries and the role of medical teams, including ambulance staff, nurses, occupational therapists, doctors and surgeons, in keeping patients culturally safe. A response is offered by Richard Kerr-Bell.

It goes dark

Saturday 18 May 2013: Local football field: *It's a drizzly, cold and cloudy Saturday. I've spent the morning transforming my daughter's old pink bike into my son's "new" blue bike, for his third birthday on Thursday. He's already able to ride without training wheels, so I'm really excited about the idea of going out for family bike rides. I've decided to play club football this season for the first time since 2006. … Now that my children are a bit older (five and almost three), I thought it might be good for them to see "the old man" out running around on the field having a good time.*

It is midway through the second half in the game … I'm breathing heavily, but feeling strong. I'm running towards the ball, which is a few metres away. I'm feeling quite happy and confident, as I know I can get to the ball. "It's mine!" I think to myself. As I'm approaching the ball, I hear heavy footsteps coming from behind me. I suspect that it's one of the opposing players who also wants the ball, but I'm in front of them. I know I will get there first. I start to turn my head slightly to the right to see if I can see what's happening behind me before I get to the ball. As I do so, I hear an effortful grunt and I'm hit, hard, somewhere on the side of my neck or head. Then I feel like I'm being forced to the ground somehow – maybe pulled back and thrown down, I'm not sure. It's rough. I feel like my head is flopping around, like I'm on a rollercoaster. I don't know which way is up. I see stars. It goes dark.

I wake up on the ground. I don't know if I'm in pain. I'm lying flat on my back. I feel tingling in my arms and legs. I've done first aid courses; I know instantly that this is a sign of spinal damage. I tell the people around me, "Don't move me!" I try to lift my head, but I can't even do that. … I'm screwed, big time! I'm lying here thinking about a life of paralysis. I'll never be able to go for walks or bike rides with my family. My kids are going to miss out on me. I'm going to miss out on them. Images of my family riding their bikes next to our local stream come to mind, but where am I? I'm really scared … I can't take this anymore, I just want to sleep (Barclay & Middlemas, in press).

Ambulance staff, with help from members of the public, put my neck in a very uncomfortable brace and placed me on a stretcher. I was then taken to the local hospital's emergency department and spent the next four days in hospital.

METHODOLOGICAL CONSIDERATIONS

Given the sensitive nature of this topic, an auto-ethnographic approach was utilised. Other investigators, for example, Clifton (2014), Dashper (2013), and Brown, Gilbourne and Claydon (2009), have also used an auto-ethnographic approach to examine personal trauma following sport-related injury. With these precedents in mind, a first-person approach is used throughout much of this text.

I undertook a critical reflection process in order to explore my experiences. Ellis and Bochner (2000) suggest that, to be an auto-ethnographer, you must be introspective about your feelings, observant about the world, self-questioning and vulnerable. It has been argued that there can be *no clear window into the inner life of an individual,* as any gaze is always filtered through the lenses of language, gender, social class, race and ethnicity (Denzin & Lincoln, 2011). Therefore, it is important to bear in mind that this research is filtered through my personal 'lenses,' which include those of husband, father, sport and exercise enthusiast, Pakeha, psychology lecturer and researcher (Barclay & Middlemas, in press).

Data collection for this project began with the generation of a dense description of the personal context of my injury and my experiences during rehabilitation. The second author (Dr Simon Middlemas) read my description and we discussed my early reflections. I revisited my notes to 'thicken' the description in parts of the narrative until 'saturation' was reached regarding my story. A series of collaborative research meetings were held between myself, Simon Middlemas and an experienced independent researcher in my academic department. These two, who acted as 'critical friends' (Smith & Sparkes, 2006), shared their own interpretations of the findings. Having lived this experience, I was best positioned to make final determinations about which themes, quotes and journal entries most accurately represented and supported my experience. Medical notes and family members were also utilised to help ensure historical accuracy (Barclay & Middlemas, in press). Co-writer Richard Kerr-Bell's knowledge includes tikanga (he is of Ngapuhi descent and has 24 years' experience in Otago working with Kai Tahu whanau) and sport experience as a coach and athlete for over 40 years.

LINKS TO PRACTICE

Saturday 18 May 2013: At the hospital: *A member of the medical team has just informed me that they are going to take my football jersey off. Instantly I think that this is not okay. "How are you going to do that?" I ask. They explain that they will take it off over my head, like you would normally take a top off. Instantly I think, "Fuck Off!" I'm still waiting to have scans and X-rays, for Christ sake! I have a neck injury, I had tingling in my limbs and they want to take my top off over my head! I'm thinking they could damage my spinal cord if they move my head. I'm not in serious pain at this moment, but I lie and tell them that I am. I tell her to just cut the jersey off because I hurt too much. They say that some people want to look after their jerseys. Given my situation, I think this sounds pretty bloody stupid. The staff member cuts the jersey off me and covers me with a robe, then goes away.*

A combination of X-rays and CAT scans identified that I had sustained a 'significant' fracture of the second cervical vertebra.

Saturday 18 May 2013: At the hospital: *I'm taken to a room in the orthopaedics ward. My wife stays with me. It's so boring just lying here – I can't move. I'm not allowed to move. I must not move. I have sandbags at either side of my head to prevent me from turning and I am in traction, with a large weight hanging off the back off my head – I'm not sure how it's attached. The doctors explain that I am going to have a halo brace attached to my head and assure me that when I have this, I will be able to get up and be somewhat physically active. ... It is getting late now, around 9pm on Saturday night. A friendly doctor comes to attach the halo to my head. I understand that I will need to have four screws inserted into my*

skull and that I'll need to wear it for 12 weeks. The doctor, with help from some nurses, has to shave a couple of areas behind each ear so that they can put the screws in for the halo.

My wife: "Gary tells me I should go home, but the nurse looks at me and says, 'It might be nice for you to stay.' Her eyes suggest that it's going to be a painful process for Gary and that he's going to need support."

My wife is holding my hand as the doctor gives me the first of four very painful anaesthetic injections in my head. Once the doctor is satisfied about their effectiveness, he begins to insert the screws into my head, two into my forehead and one to the rear of each ear. It feels really strange having something screwed into my head. I can feel every turn and I can hear and feel the crunch of my bone as the screws are gradually secured into my skull. There is a lot more pain with one of the screws. I tell the doctor. He applies more anaesthetic; we wait for it to be effective and then he tries again. Eventually, the halo and screws are all in place. Now I have to wait until Monday for attachment of a special vest.

Questions for practice

This article is based on my experience of traumatic injury. Although I identify as a New Zealand Pakeha, aspects of my experience could be relevant to people from other cultures. For instance, people from many cultures, including New Zealand Maori, are involved in contact sports, which have the potential for high-impact injuries similar to those I sustained. Further, my reflections on my experiences may be useful to medical teams; those suffering injuries; those with family, friends or team-mates who have been injured; as well as those working with injured people such as ambulance staff, nurses, occupational therapists, doctors and surgeons.

I acknowledge that my injury experiences and interpretations are unique to me – so, what is the journey like for others? I know little of cultures other than my own, but I do know that to some the head is tapu (in the case of New Zealand Maori), or of importance and deserving of respect. My experience brings to mind a number of questions which may deserve further attention from the medical community and others: How would people from such cultures cope physically, mentally, emotionally and spiritually with similar experiences? How would they cope with people physically handling their head and neck region in the immediate aftermath of a high spinal cord or head injury? How would they cope with having a halo brace screwed into their skull? What steps would or could medical teams take to ensure the cultural safety and security of a person having an experience similar to mine? Further, if a patient's cultural needs were not met during treatment, how might any 'wrongs' be made right?

The aim of this article is to stimulate discussion of the potential influence of cultural perspectives on the treatment of serious head-region injuries and the role of medical teams in keeping patients culturally safe. By reflecting on my experience and some of the questions posed above, we might be able to better appreciate and understand the needs of others.

A RESPONSE FROM RICHARD KERR-BELL

Ko Hunoke te maunga mai I tenei tut tapu ka titiro atu ki te moana o Hokianga, e rere ana, e rere ana ki te awa o Waiwhatawhata. Ka papatu tenei I te taha o toku marae o Aotea me the Whare Tupuna Te Kai Waha, he taonga mo te hapu o Ngati Wharara I te Iwi o Ngapuhi. Ko Ngatokimatawhaorua te waka.

Gary has raised questions about appropriate, or tika, practice to support practitioners, patients and whanau who may seek guidance about treatment for head injury, given traditional and current beliefs about the head as tapu (Ihimaera, Long, Ramsden & Williams, 1993). I propose to share my understanding of such questions and where that knowledge has come from, as well as drawing on existing commentary to guide our responses to medical treatment

of the head, especially for those who believe that the head is tapu, sacred, or set aside for particular purposes (Mahoney, Scott, Sorrento, 2014).

There are inevitably many possible responses that reflect the confluence of traditions associated with whanau, hapu and iwi and contemporary thinking and treatment possibilities. Some responses involve direct and invasive actions, others require contact with hands or implements and are more surface-based treatments. According to Naida Glavish, who is the chief tikanga advisor to the Auckland District Health Board and has contributed significantly to best practice at the Southern DHB, all users of health services are to be treated with dignity and respect. In turn, users of health services are expected to behave respectfully. If these practices are honoured, the outcomes will be threefold: raised levels of awareness and confidence in the health workforce; a greater consideration of wider cultural needs and expectations; and improved access to, and effectiveness of, mainstream services for Maori.

Where the removal of body parts is required, practitioners should "Assist in properly removing, returning or disposing of body parts/tissues/substances in consultation with patients and/or their family and in accordance with Maori protocol." This process should be followed regardless of how minor the procedure (for example, removal of nail clippings, hair or blood) is perceived to be by staff. All discussions should be non-directive and follow an informed process (SDHB Tikaka Best Practice, 2005).

Many Maori rituals are underpinned or retained culturally through stories, legends, waiata, whakatauki and a variety of culturally expressed media. One example is the story of Rata. The abbreviated version presented below is adapted from the retelling of the legend by Wiremu Grace (2012):

In seeking a tree to build waka to help out his village, Rata found one and proceeded to chop it down. Returning the next day, he saw that the tree was right back in the place where he had found it, standing strong and tall and well-rooted into the ground. So once again, he took his toki (or axe) to it and returned again the next day, only to find it in the same healthy state in which he had first found it. Suspicious and confused, he hid in the bushes after his third attempt and discovered that the children of Tane were putting the tree back together piece by piece, shaving by shaving, branch by branch. He jumped out to challenge them. Angrily at first, they admonished him for not paying due respect to Tane, god of the forest, before taking the tree to repurpose it. Head bowed, Rata acknowledged his mistake, at the same time revealing that his motivation was to help his village. So, in the end, the children of Tane helped him create a magnificent waka.

The lesson of this story is that one must always acknowledge the whakapapa, mana and relationships in the environment, both natural and social.

To put things simply, I believe that today, with medical and technological innovations and applications so ubiquitous, one can still acknowledge the tapu of a place, thing, person – or head – and work with it or around it, showing an attitude of respect and protection, to use that term. Thus doctors, nurses, and other staff may act in accord with the permission given by the patient or their whanau, and through karakia or other cultural means provide a safe pathway.

When as often happens, the head, hair or part of the skull may require removal or modification, at the beginning or at some stage during the procedure, the karakia performed by the whanau, kaumatua or chaplain is able address the tapu of the head and its material, spiritual, and whakapapa significance to allow medical staff to perform their necessary actions with due attention to the patient's cultural needs.

The tapu status ascribed to the head in particular refers to the belief that it contains a person's whakapapa – and, by extension, their lineage, and the mana and matauranga or knowledge that forms a relationship to the people or atua where it originated. In addition, these persons, beings and elements remains real, living, and in present existence. I have acquired this knowledge through living for periods with my uncle in my rohe of Hokianga, and through working with kaumatua from a variety of iwi, mostly over the last 25 years, including Ngapuhi and Kai Tahu.

One of the challenges in any human interaction where values and principles differ – or at least use different terminology, language and interpretations – is to cross the cultural gap through the forming of a relationship, albeit a temporary one (chronologically, at least). Taking account of factors such as stress, tiredness, professional focus and time limitations, this relationship of respect can facilitate an element of trust that opens the ears and, more importantly, the hearts and minds, of those gathered to encourage them share the same goal, and to allow each to proceed and process those elements required to be professionally and culturally satisfied that the right path or tikanga has been addressed.

"Ki te oti te taha wairua, mama te taha kiko" (Ratana, 2000). When the spiritual aspects of life have been addressed, the material takes care of itself.

CONCLUSION

As a result of the diverse cultural belief matrix of patients and their families in New Zealand, the treatment of traumatic injuries requires sensitivity and awareness. Hospitals and care facilities with New Zealand-trained medical staff have significant resources available and easy access to information and training, thus enabling Māori cultural norms and traditions to be realised. This approach does require respect, listening and trust.

The attitudes of many health professionals in New Zealand to the diverse cultural practices of patients and their whanau has certainly come a long way from making front page news in the *Otago Daily Times* and in many places this awareness and openness has become the norm. We will do well to keep in mind the stories of Gary and of Rata, which remind us to tread carefully and respectfully when we walk in the world of others.

Gary Barclay is a senior lecturer in sport, exercise and health-related psychology at Otago Polytechnic's Institute of Sport and Adventure. He completed a Masters in sport psychology at the University of Otago in 2004 and has since completed graduate studies in psychology through Massey University. In addition to his teaching, Gary has consulted with a variety of individuals and groups in sport and performing arts contexts. He is now enjoying the opportunity to further his research interests in a number of areas including the influence of exercise on mental health and recovery from serious injury.

Richard Kerr-Bell (Ngapuhi, Ngati Kuri, Te Rarawa) works with the Otago Polytechnic's kaitohutohu team, overseeing Kai Tahu students with CapableNZ and Māori student support at Te Punaka Owheo. He has a background in counselling, teaching, theology and management. Richard also has a keen interest in sports coaching, writing and leadership issues. His community involvement includes leading roles in the Southern Maori Business Network, the Green Island Football Club and the Runanga o te Hahi Katorika ki Aotearoa. Richard has published three books: Enjoy Your Life, A God of Love and From Rangi Point in Bare Feet.

Simon Middlemas is a principal lecturer and research coordinator at the Otago Institute of Sport and Adventure at

Otago Polytechnic. He completed a PhD in sport psychology and performance analysis in 2014, focused on the use of video feedback in the psychological preparation of elite youth football players and coaches. For the past decade, Simon has worked as a sport psychology consultant within elite and development sport, for the English Institute of Sport (EIS) and as a private consultant, with clients such as GB Swimming, GB Volleyball/Beach Volleyball, England Netball, the British Equestrian Federation and the English Football Association. He completed a Graduate Diploma in Tertiary Education in 2015.

Correspondance to: Gary Barclay, College Te Oha Ora, Sargood Centre, Otago Polytechnic, 40 Logan Park Drive, Dunedin 9016, New Zealand. Email: gary.barclay@op.ac.nz

REFERENCES

Barclay, G. & Middlemas, S. G. (in press). *I'm screwed:* A personal perspective on the influence of 'schema' in response to and recovery from serious injury. Journal New Zealand College of Clinical Psychologists.

Brown, G., Gilbourne, D., & Claydon, J. (2009). When a career ends: A short story. Reflective Practice, 10, 491-500.

Clifton, S. (2014). Grieving my broken body: An autoethnographic account of spinal cord injury as an experience of grief. *Disability and Rehabilitation, 36,* 1823-1829 doi: 10.3109/09638288.2013.872202.

Dashper, K. (2013). Getting better: An autoethnographic tale of recovery from sporting injury. *Sociology of Sport Journal, 30,* 323-339.

Delamore Support Services. (2017). Tikanga Guidelines (Issue 1). Retrieved from http://delamoresupport.co.nz/file/dss_tikanga_guidelines_issue-1.pdf p3 (2017)

Denzin, N.K., & Lincoln, Y.S. (2011). *The SAGE Handbook of Qualitative Research (4th ed.).* Thousand Oaks, CA: SAGE Publications, Inc.

Ellis, C. S., & Bochner, A. (2000). Autoethnography, personal narrative, reflexivity: Researchers as subject. In N. Denzin & Y. Lincoln (Eds.), *The Handbook of Qualitative Research* (pp. 733-768). Thousand Oaks, CA: Sage.

Grace, W. (2012). The story of Rata and the tree. Retrieved from https://www.careers.govt.nz/assets/pages/docs/rata-and-the-tree-story.pdf

Ihimaera, W.T, Long, D.S, Ramsden, I, Williams, H. (1993) Te Ao Marama: He whakaatanga o te ao: the reality. Reed Books. P28.

Medical Health Council of New Zealand (2008). Best health comes for Māori: Practice implications. Retrieved from https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Maori.pdf (P13).

Scott, K., Sorrento, S., & Webb, M. (2014). Long-Term Caring - e-Book: Residential, home and community aged care. Retrieved from http://www.elsevierhealth.com.au/long-term- caring-9780729541916.html

Smith, B., & Sparkes, A. C. (2006). Narrative inquiry in psychology: Exploring the tensions within. *Qualitative Research in Psychology, 3*, 169-192

Southern District Health Board (2005) Tikaka best practice. Retrieved from http://www.southerndhb.govt.nz/files/20091025164500-1256442300-2.pdf and referred to at http://www.southerndhb.govt.nz/pages/our-vision-and-focus-and-principles/