Cancer inequities for Māori: the journey and clinical decision-making

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Background

• There are persistent inequities in cancer survival for indigenous peoples, including between Māori and non-Māori

• Evidence that Māori receive poorer quality care

• Cancer patients with comorbidity are considerably less likely to be offered active therapy despite growing evidence of effectiveness

• Māori more likely to have comorbidity
Aim & Approach

• Aimed to understand the cancer journey and clinical decision-making for Māori and how health care delivery leads to unequal outcomes

• Māori-centered research: Māori Co-PI, Māori researchers, tikanga, te reo, generating gains for Māori, strengths-based approach

Key finding

• No particular area stood out as a site of discriminatory practices

• Rather, there are many different processes and interactions that can have a discriminatory impact
Phase 1

Decision-making in multidisciplinary teams

Methods

Internationally, multidisciplinary team meetings (MDMs) are increasingly the context within which cancer treatment decisions are made

• A systematic literature review

• Recording of 10 MDMs (breast, colorectal, upper GI & lung)
Comorbidity

• Comorbidity not systematically discussed in MDMs & members likely to be unaware how much it is ignored

• Comorbidity can result in under treatment

• Māori suffer more comorbidity

• Consideration of comorbidity in MDMs is a process where discrimination can occur

Implication:

• Assist clinicians to undertake MDM decision-making that appropriately addresses comorbidity - toolkits to evaluate MDM decision-making
Meeting the Patient

• The clinician who has met the patient tends to be treated as if they have ‘undisputable knowledge’ of the patient - ‘encountered’ authority

• Clinicians make assessments about people’s levels of support, habits and so forth that are based on categories of ethnicity and class

• So encountered authority in MDMs is a process where discrimination can occur

Implications:

• Clinician awareness of stereotyping & ways to address it – initial & in-service training

• Validated assessment tools to reduce subjectivity in assessment e.g. ‘level of frailty’ in relation to surgery

Not meeting the patient

• If no one has met the patient discussions can be difficult as ‘all’ information may not be at hand at the MDM

• This may disadvantage some patients e.g. from provincial hospitals

• Māori more likely to live in provincial areas

• So lack of encounter of MDM patients is also a process where discrimination can occur

Implications:

• Use processes that ensure all patients are met prior to MDMs by clinicians cognisant of stereotyping

• Use video-conferencing to link in clinicians from provincial areas
Phase 2
Consultations

Methods

• Audio-record 18 consultations where treatment decisions were discussed
• Clinician debrief
• Patient & whānau interview post-consultation
OPTIONS FOR DECISION-MAKING

- **Outright recommendation** – clinicians present case in absolute terms, providing little opportunity for patient participation in the decision-making. Clear treatment pathway for which the benefits substantially outweigh the risks. Occurred in 1/3 of consultations.

- **Favoured decision** - clinicians build a case for an option but the possibility of an alternative is available. Occurred in 1/3 of consultations.

- **Open decision** - clinicians provide information without making a clear recommendation. High level of uncertainty about the benefit vs. risk of treatment.
Decision-making

• Māori more likely to have complex cases due to comorbidity

• Thus more likely to be presented an open decision requiring difficult decision-making

Implication

• Increased attention to the consequences of this may reduce inequity in outcome

Phase 3

Patient Journeys
Method

• Semi-structured interviews with 34 participants, 19 Māori & 15 non-Māori with and without comorbidity
Results

• Overall people largely reported being satisfied with their care

• Māori and non-Māori participants reported similar experiences
  – cancer is an unwelcome and foreign world
  – with complex medical terminology &
  – patients need support people

• However, Māori need culturally appropriate health services

Implications

• Make the world of cancer less foreign
• Ensure health professionals use clear & understandable lay language
• Enable support people to fulfill their role
• Invest in culturally appropriate services for Māori e.g. cultural competence across the health sector, Māori ‘navigators’ to assist patients to navigate the system
Conclusion

• There are many different processes and interactions that can have a discriminatory impact during the cancer journey.

• ALSO as colonised peoples Māori experience inequities in nearly all determinants of health.

• As a result the complex world of cancer may be even more difficult to navigate for Māori.

• There is no one solution. Closing the gap in cancer survival for Māori will likely take multiple efforts at all levels within health and across society.

• Hope our work may provide some solutions in the NZ context & provide clues to address inequities in cancer survival amongst other indigenous peoples.

References

