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Decision-making for wāhine Māori facing breast cancer surgery: a qualitative study

Vanessa Burrett [a], Tania Blackmore [b], Kimberley Norman [c], Karen Turanga [c], Jenni Scarlet[d], Ian Campbell [d] and Ross Lawrenson [c]

[a]Cancer Psychological and Social Support Service, Te Whatu Ora – Health New Zealand, Hamilton, New Zealand; [b]Te Kura Whatu Oho Mauri – School of Psychology, University of Waikato, Hamilton, New Zealand; [c]Te Huataki Waiora – School of Health, University of Waikato, Hamilton, New Zealand;; [d]Breast Care Centre, Te Whatu Ora – Health New Zealand, Hamilton, New Zealand

ABSTRACT

Wāhine Māori (women/females) are disproportionally affected by breast cancer in Aotearoa New Zealand. Following a breast cancer diagnosis, wāhine must make important surgical decisions while navigating a Westernised health system that can be dismissive of Māori views of health and tikanga (customary practices). We investigated the decision-making process of wāhine who had undergone surgery for breast cancer within the preceding 12 months. Fifteen wāhine shared their perspectives on surgery, shared decision-making and information provided prior to surgery. Thematic analysis revealed that fear was a primary influence on decision -making, but this emotion could be mitigated by a good quality patient-clinician relationship fostered by the shared decision-making process. In particular, whakawhanaungatanga (establishing connection and relationships) was an essential basis for shared decision-making. Shared decision-making, in turn, enabled tino rangatiratanga (self-determination) and provided support during the difficult decision-making period. Multi-modal presentation of medical information, with inclusion of Te Reo Māori is relevant to many wāhine and could offer more equitable access to diagnostic information. These findings raise awareness of the importance of recognising tikanga, in particular, whakawhanaungatanga for wāhine Māori diagnosed with breast cancer.

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Introduction

Wāhine Māori (women/females) have a high incidence of breast cancer (BC) in Aotearoa New Zealand (NZ) (Lawrenson et al. 2016), with a BC registration rate 1.4 times higher than non-Māori (Ministry of Health 2018). In accordance with Te Tiriti o Waitangi, the NZ government has a responsibility to ensure equitable access to healthcare for Māori (Scott et al. 2020). However, Māori continue to face healthcare inequities associated with European colonisation (Graham and Masters-Awatere 2020) that has contributed

CONTACT Vanessa Burrett vanessa.burrett@waikatodhb.health.nz

to a widespread pattern of institutional racism (Kereama-Royal et al. 2019) and lack of culturally responsive approaches by health services (Wilson 2008). For example, Māori experience worse outcomes following a BC diagnosis than non-Māori (Gurney et al. 2020) and are subject to significantly longer delays for appointments and treatment (Tin Tin et al. 2018), including breast cancer surgery (Seneviratne et al. 2015a).

Surgical treatment for BC involves breast conserving surgery (BCS) aiming to preserve the breast, or removal of the breast through mastectomy. If clinically indicated, women may also have the option of breast reconstruction using either implant-based techniques, autologous flap (usually latissimus dorsi flap) with implant, or autologous (TRAM/DIEP/LD) flap without implant. Waikato data from 2000 to 2013 shows that Māori and Pasifika women were less likely to undergo breast reconstruction (Campbell et al. 2018; Seneviratne et al. 2015b), a trend that has also been reported nationally (Breast Cancer Foundation NZ 2022). While patient and surgeon factors contributing to this disparity are unclear, known factors include higher socio-economic deprivation, with Māori less likely to receive surgical treatment through private care (Seneviratne et al. 2015b), and higher obesity and smoking rates which can increase surgical risk (Lee et al. 2019) and poor outcomes (Singareeka Raghavendra et al. 2022).

Historic disparities in health care have placed a special focus on Māori engagement during medical encounters. To facilitate positive experiences for Māori, the Hui Process – a national framework for engagement between medical professionals and Māori provides a guide to these interactions (Parry et al. 2014). The Hui Process includes mihi (initial greeting), whakawhanaungatanga (the practice of establishing connection and relationships), kaupapa (addressing the purpose of the encounter) and poroporoaki (concluding the encounter) (Lacey et al. 2011). Whakawhanaungatanga, the second step in The Hui Process, is particularly integral to the establishment of trust and engagement between patient and clinician (Komene et al. 2024). This emphasis on connection when engaging in whakawhanaungatanga is deeper than that of rapport building in that it is a reciprocal exchange in the patient-clinician relationship (Wilson et al. 2021).

Establishing a positive patient-clinician relationship becomes fundamental in the period following a BC diagnosis, when all women must consider a number of factors before deciding on surgical treatment. Shared decision-making – a collaborative process between patient and clinician – aims to help both parties decide on the best treatment option (De Mik et al. 2018). Shared decision-making is associated with positive outcomes (Clarke et al. 2021) and is considered integral to quality cancer care (Maes-Carballo et al. 2020). The shared decision-making process is comprised of multiple components, which include but are not limited to, clinicians discussing treatment options, getting to know the patient – incorporating the acknowledgement of patient treatment preferences – and the provision of tailored information (Bomhof-Roordink et al. 2019). Shared decision-making within the NZ context is not well researched but has potential benefits for Māori in that it offers an opportunity to deliver culturally responsive care while honouring Te Tiriti o Waitangi (Czuba et al. 2023). For example, in addition to models such as The Hui Process, shared decision-making could also be a vehicle to improve recognition of tikanga (customary practices) such as manaakitanga (respect and care of others) (Wilson et al. 2021) which is a key facilitator for Māori accessing health services (Espiner et al. 2021). Moreover, shared decision-making for Māori

should enable a collectivist approach, ultimately recognising the role of whānau as an extension of the Māori patient (Wilson et al. 2021).

Given its importance when engaging with Māori, we theorise that whakawhanaungatanga is an important stepping stone to facilitate the shared decision-making process for wāhine Māori experiencing BC. With the paucity of NZ-based research on shared decision-making specifically pertaining to Māori and the role whakawhanaungatanga might play in this process, we investigated the decision-making process for wāhine Māori prior to breast surgery. This study reports the findings from qualitative interviews exploring the decision-making experience for wāhine Māori who had undergone breast surgery – either BCS, mastectomy or breast reconstruction – in the preceding 12 months.

Materials and methods

Participants had been previously surveyed as part of a broader quantitative study (unpublished data) involving 137 women with stage I-II BC who had received surgery in the preceding 12 months. Participants were recruited through Te Whatu Ora Health New Zealand Waikato (former Waikato District Health Board; patient population of 400,000 +) where a high proportion of wāhine Māori live (Breast Cancer Foundation NZ 2022). Eligible patients were informed about the study via an anonymous text message (TNZ Group) which contained a survey link and provided access to a digital consent form. Following the survey, participants were asked for further consent to take part in an in-depth qualitative interview. Those who had consented to interview from the larger study were purposively sampled to gain a cohort of wāhine Māori who had undergone either BCS, mastectomy or mastectomy with breast reconstruction. Sampling gave a cohort of 14 wāhine Māori and one Pasifika (Cook Island Māori) participant eligible for study inclusion. Following consent, participants were contacted to arrange an interview day and time. All interviews were intended to be carried out in the participant's home, but following COVID constraints, were carried out via Zoom or telephone. Interviews were conducted between January and March 2022 by two female researchers. Verbal consent was obtained and recorded via Dictaphone prior to interview commencement.

Interviews were semi-structured but followed a loose format directing participants to discuss their thoughts about surgery, shared decision-making and understanding of information. While this loose format was followed, wāhine were encouraged to speak freely about all aspects of their experience. Prior to interview commencement, the study aims were restated, and participants were reminded of confidentiality and right to withdraw. Participants were also invited to begin the interview with karakia (prayer) and koha (gift, donation) was offered to wāhine during home visits. All interviews were recorded via Dictaphone and transcribed using online transcription service Otter.ai. The right to amend or review transcripts was offered to all participants. Interview data were analysed using thematic analysis for the identification and coding of themes. Analysis was initially undertaken independently by the main interviewers (TB and KN), which was followed by a collaborative process which also included a Māori clinical psychologist (VB) and a Māori researcher (KT). Whilst Braun and Clarke (2021) highlight that the ability to achieve data saturation is situated and subjective, this analysis found no new themes during the collaborative review.

Ethical approval for this study was granted by the University of Waikato Human Research Ethics Committee (HREC (Health) 2021#78), with funding support from a Health Research Council of New Zealand Career Development Award (Ref: 21/961).

Results

Participant characteristics are shown in Table 1. The themes identified are presented according to the interview framework: thoughts about surgery, shared decision-making and access to information prior to surgery.

Prioritising cancer removal

Cancer removal was a significant factor influencing surgical decisions, irrespective of the type of surgery received. Some wāhine described urgency in getting the cancer 'gone'. This sense of urgency was usually accompanied by a fear of their disease spreading, which could potentially impact survival:

> With ductal carcinoma, it was mastectomy regardless. Sweet whack it off. Get rid of it. Get rid of the yuckies. BC53, age 57, Breast reconstruction (DIEP)

For some wāhine balancing a sense of urgency for removal and fear of cancer spread meant that making a treatment decision was a simple or quick one, without much deliberation:

> Yeah. It was simple for me – my way of thinking and it was that simple, you're either gonna die faster or, you got a better chance of living longer if they just remove it. BC57, age 59, Mastectomy alone

> I was quite happy with the lump removal. I don't really question that at all. So I kind of knew, you know, that removing the lump was, was the only way to go. BC34, age 57, BCS

Getting well for whānau and whanaunga (extended family) was also evident in thoughts about prioritising cancer removal and treatment decisions. Some wāhine described being content with their decision, as this was the quickest path to getting back to their whānau:

> My first thought to them [family] and we have two little grandchildren. And it was the most quickest … So we were able to make a clear decision, but basically it was the quickest, swiftest action that would get me back to our family. BC60 age 51, BCS

Table 1. The characteristics of wāhine who had undergone breast cancer surgery (BCS, mastectomy alone or breast reconstruction) in the previous 12 months ($N = 15$).

Characteristic		*n*	%
Age group	<40	0	0
	40–45	2	13.3
	46–50	1	6.7
	51–55	4	26.7
	56–60	5	33.3
	60+	3	20
Ethnicity	Māori	12	80.0
	NZ European/ Māori	2	13.3
	Cook Island Māori	1	6.7
Surgery type	BCS	9	60
	Mastectomy alone	3	20
	Breast reconstruction	3	20

Actively appraising evidence

Some wāhine described appraising the clinical evidence that was presented to them by their clinicians. For these wāhine, there was a sense of not merely passively receiving this information, but actively considering it within the overall context of their cancer and personal preferences for treatment. From the narratives provided, there was a sense of tino rangatiratanga evident in these appraisals, where wāhine reported having self-determination over their bodies and treatment decisions:

> I would have (had a mastectomy) if the evidence matched the decision. You know, like, if that was the only option, then that's what I would do. BC28, age 64, BCS

> So I sort of come up with the idea that I did want to get the other one removed. And if I had to go private, I would. BC20, age 42, Mastectomy alone

> I'd made the decision once the moment they said that I had cancer and they were going to take the breast off. I wanted the other one off … So, thinking that you're done, and then like on the dotted line, yes, I want both breasts off, ah, was one of those things that felt quite momentous. BC52, age 57, Breast reconstruction (DIEP)

Facing breast removal

Those facing mastectomy approached their surgery pragmatically, which facilitated a feeling of acceptance with the decision to have their breasts removed. For example, some wāhine described viewing their breasts functionally, and as having served a practical purpose that was now over:

> I remember saying when I got given my diagnosis. I remember saying they've done their job. It's okay. BC53, age 57, Breast reconstruction (DIEP)

> It was never really about what it looked like … how I as a woman would feel. I've had my children, you know, they were functional. BC60, age 51, BCS

In contrast, the narratives of other wāhine illustrate the individual nature of making decisions about breast surgery. Some wāhine expressed a fear of losing a breast, and a sense of relief when this was not needed. For these wāhine, a sense of normalcy was alluded to, as well as the impact losing a breast might have had on mental health, and the feeling of societal pressure:

> [I'm glad because] you want to look normal. Because I guess if it wasn't there, I would be so conscious and probably, really uncomfortable in public. BC26, age 57, BCS

> I think if I'd had a mastectomy, I don't know that I would have been in the same place in my head. I think I might have felt a little bit taken a bit away from me as a woman, yeah, definitely. BC54, age 68, BCS (with reduction)

Shared decision making prior to surgery

Wāhine were asked about the shared decision-making process prior to making treatment decisions. Establishing a good relationship with their surgeon was clearly important during this time and is reflective of whakawhanaungatanga. For one participant, whakawhanaungatanga supported her being open to other treatment options. After initially

being determined to have a mastectomy, it was her surgeon that took the time to establish a good patient-clinician relationship with her, which in turn then meant she was open to considering another choice:

> And he did tell me right from the beginning that there was another option, but I refused to listen to it until the second, second consult where he was a lot more detailed about it. And by then, you know, we had built up you know, I've come to trust and I was really grateful. And he, the way he explained that, it gave me the same level of comfort that I would get rid of it either way. BC60, age 51, BCS

There was also evidence of manaakitanga in some of the interactions described, where some clinicians took time and showed care and respect with their patients. One wahine illustrated how being made to feel reassured gave her a sense of confidence in her surgeon, which ultimately had a positive impact for her:

> And I walked out of there just feeling reassured. We had quite an in-depth discussion … I just felt I had more confidence after seeing her. You would have thought I was two different people in those two days … I was very thankful for that. BC61, age 52, BCS

Care and respect from a clinician was also reported by another wahine, who reflected how after she was informed of her diagnosis, her clinician showed her respect by giving her the time to absorb this information, which helped her to feel safe:

> So, he [surgeon] gave the news. And he asked, if I was okay, and he said he was going to leave the room for five minutes, so I could have time to grieve and just process … So, he gave that private moment. So, I felt completely safe, I felt cared for. BC53, age 57, Breast reconstruction (DIEP)

Tino rangatiratanga was another important outcome of the shared decision-making process and was evident in those narratives where wāhine expressed having a sense of control over what was about to happen to their bodies. One participant reported an excellent exchange with her surgeon after borderline disease was revealed in her healthy breast, showing how tino rangatiratanga was enabled for her:

> And I think because he knew I was very set in my mind on how I was that he never really, he didn't really have to um, how would you say, yea, he just followed, he basically followed lead … I was very, very in control of my destiny … It's about the patient actually having control, this is their body. BC20, age 42, Mastectomy alone

Other participants also reflected on how having a sense of self-determination facilitated positive feelings about what should have been an inherently negative experience:

> I mean, I'm well aware that any time I could just say, no … I was given that choice in my first round of treatment … they laid out all the options. And went you could do this, you could do this, you could do this, or you could do nothing. You could do absolutely nothing. The choice is yours. BC23, age 44, Breast reconstruction (implant)

> I mean, thank God, I had good surgeons who let me choose. And that through the whole process that I was in the driver's seat, being able to choose what I wanted for my body, and I love that. It really left me with a, with a good experience out of a negative situation. BC52, age 57, Breast reconstruction (DIEP)

However, tino rangatiratanga was not an outcome of the shared decision-making process for all wāhine. One participant reflected on how she and her husband felt no control over their health choices, which lead to feelings of hopelessness about her diagnosis:

> Because the first clinician I saw who gave me the results, my husband and I felt like we had no choice but to have a mastectomy. And, and not even choices around that, whether that would be a single mastectomy or a double mastectomy. And he kept telling me that I was overweight, so I wouldn't be considered for a reconstruction. And basically, we just felt hopeless, at the end of it all. BC54, age 68, BCS

The experience of another wahine illustrates how poor interactions with health professionals led to an overall negative perception of the whole experience. This participant did not feel like her preference for treatment was heard, resulting in her having BCS rather than a mastectomy, and she was ultimately unhappy with her surgical outcome:

> I said to the specialist, nah I rather get it, the breast taken out. She just wanted me to save it … when I had a look after I went for it, I was thinking, oh, my gosh, I should have got it taken out anyway, because it looks lopsided. And it looks stupid, yeah … it looks ugly and it looks lopsided. BC01, age 48, Māori, BCS

Information prior to surgery

Many wāhine reported shock and distress on receiving their cancer diagnosis, which is the time that patients are generally also provided with important diagnostic and treatment information. Wāhine reflected on how this shock impacted their ability to retain the diagnostic information presented to them. For example, one wahine highlighted that her concentration was impaired during her consultation due to thoughts of death and intense fear as soon as she heard the word 'cancer':

> It's just completely shut, you know, shut down. That's it. First time when I had that, I, I was blackout. Like, you know, I couldn't follow what else that you exactly what you were saying? Because you can't, you're not focused on what they were trying to tell you. But the word cancer is like, this is the end of your life. BC18 age 52, BCS

While diagnostic shock can provide a barrier to information absorption, so too can the volume of information provided. One wahine reflected that while taking in information during a consultation was too much, having a booklet to take home was useful to refer to post-consultation when she had had time to process her diagnosis:

> I was able to go in and actually read up on the one that he'd given me even though he explained it, you know, you get home and you think, oh, what did he say? So the booklet was really helpful. Because you could go back in and have a look at it. BC28, age 64, BCS

The mode in which information was presented was also significant to understanding the surgical options available. While patients are typically provided with written information, one wahine described the importance of having an alternative visual mode, with less highly clinical terminology that might better suit differences in an individual's learning style:

> You know I didn't want to keep listening to you know, all the stuff that I didn't even understand. That's what I mean about if they had showed me a video about what they are talking about I could understand it better. BC57, age 59, Mastectomy alone

For wāhine who expressed being of a visual learning style, being provided with photos or drawings helped to demystify the surgical process and supported informed decision-making. For one participant, pictures softened her perceptions around, and determination to have, a mastectomy:

> She, I'm quite a visual person, and she drew pictures for me! About how the process went, and I was so thankful because it made me you know, just see how it all works, and what was going to happen. And she could even visualise what, what my boob would look like after … I was in a much better mindset. BC61, age 52, BCS

> But he said, there is another way we can get this out. And it took a lot of convincing from his part, the surgeon, well he didn't actually push it, but he's explained it and drew pictures and so in a way that I felt, okay I don't have to have the whole lot taken off. BC60, age 51, BCS

Another participant suggested that having information inclusive of her language would have been helpful to her and her decision-making:

> I mean, for me, I believe as an Islander, because it's a second language. You know, we should have somebody in there that can translate the language … I would love somebody there, you know to break it down, like you know, more to explain more in our language. BC18 age 52, BCS

This 'translation' was also positioned as a need to transcend the literal definitions of language and adopt a softer delivery of medical information. One wahine expressed in addition to translating information into Te Reo, presenting information in a way that is accessible would also be useful:

> They [including a Māori person for translation] might be able to help write [information booklets] in an um, not a better language, but more to how they think it would be received by the Māori or Pacific Islander. If you know what I mean? Take away some of the jargon and put in what they would say. BC28, age 64, BCS

Discussion

As with most women diagnosed with BC, fear was a significant factor influencing decision-making for wāhine Māori. However, fear could be mitigated by a foundation based on whakawhanaungatanga, which was especially important to facilitate shared decision-making and support wāhine through the decision-making process. Irrespective of the type of surgery received (e.g. BCS versus mastectomy and breast reconstruction), shared decision-making in turn enabled tino rangatiratanga for those wāhine who were engaged in a collaborative process with their clinician. The simple, multi-modal presentation of information, inclusive of pictures or diagrams and greater inclusion of Te Reo Māori may improve the presentation of treatment information and provide equal opportunity for access to medical information.

Fear as an emotional response to a cancer diagnosis is a typical emotion felt by most women (Dicks et al. 2019; Rosenberg et al. 2018, 2019). Wāhine in the current cohort expressed wanting to do whatever it took to remove the cancer as fast as possible, both for their own survival and survival for whānau. Indeed, irrespective of surgery type, wāhine expressed urgency of cancer removal, highlighting the importance of swift action to those interviewed. A factor associated with this urgency was whānau and whanaunga, which reflects the Māori view of themselves not just as an individual entity, but as part of a collective that includes immediate and extended whānau (Wilson et al. 2021). Whānau members play a key supportive role for patients, to the extent that their involvement is associated with positive health outcomes (Graham and Masters-Awatere 2020). This highlights the importance of understanding the role of whānau as an integral cultural consideration that has implications for shared

decision-making, and ultimately, patient welfare. In practice, this means continued recognition of the inclusion wider whānau throughout the BC journey (Graham and Masters-Awatere 2020).

Whakawhanaungatanga is also especially important (Slater et al. 2013); it forms the basis of Māori Models of Health (Wilson et al. 2021) and its absence can have negative implications for Māori engagement with health services (Levack et al. 2016). Our findings suggest that whakawhanaungatanga was an important medium to establish shared decision-making; it helped wāhine to feel connected, safe and supported. Whakawhanaungatanga also has the potential to facilitate open patient-clinician dialogue that could help to alleviate whakamā (feelings of shyness, embarrassment) and provide a safe space to address future health concerns. Certainly, the few wāhine who expressed not feeling heard, perhaps an indication of the absence of whakawhanaungatanga, reported fewer positive outcomes and lower satisfaction with surgical outcomes. We reiterate the importance of whakawhanaungatanga to establish trust and connection. In practice and in accordance with The Hui Process (Lacey et al. 2011), this means that a key difference when engaging with Māori versus non-Māori is that health care professionals should also recognise the reciprocal nature of whakawhanaungatanga and exercise sharing information about themselves in order to foster this connection (Wilson et al. 2021).

Our findings suggest that whakawhanaungatanga was a facilitator for the shared decision-making process, which reimagines the clinician-patient relationship from a patient-centred viewpoint (Mazzocco et al. 2019). Shared decision-making was positively engaged in by almost all of the wāhine interviewed. A part of this process was the provision of good diagnostic and treatment information, where mode of information delivery is an increasingly important consideration. Research has now shown the effectiveness of presenting medical information via visual formats to improve patient comprehension (Alam et al. 2016; Durand et al. 2016, 2021; Meppelink et al. 2015). Our findings support this evidence. While having written information was viewed positively, visual information helped alleviate anxiety and assisted wāhine to feel at ease. Perhaps more importantly, showing manaakitanga through tailoring information delivery with photos, pictures and diagrams enabled tino rangatiratanga and solidified whakawhanaungatanga; surgeons who took the time to draw even the most rudimentary of diagrams showing how post-surgery breasts might look helped wāhine feel cared for and respected. With medical information typically presented in written format that may not be responsive to the cultural norms of other ethnic groups (Grabinski et al. 2018), it was also interesting to note that some of the wāhine interviewed recognised that providing medical information inclusive of Te Ao Māori would observe manaakitanga and offer more equitable access to diagnostic information.

Considering the historic inequity and mistrust Māori have experienced (Graham and Masters-Awatere 2020; Kereama-Royal et al. 2019; Wilson 2008), it was interesting to note that some wāhine expressed a sense of empowerment and tino rangatiratanga in their health decisions. Many wāhine were not simply passive receivers of medical information, which led to a positive appraisal of their BC experience: '*a good experience out of a negative situation*'. The shared decision-making process should inherently facilitate tino rangatiratanga for Māori (Czuba et al. 2023) and aligns with The Hui Process, a framework to facilitate clinician-patient relationships that has been a key guideline in

NZ healthcare since 2011 (Lacey et al. 2011). Assessing adherence to The Hui Process was beyond the scope of this study. Patients are likely unaware of these guidelines for engagement with Māori, so we can only infer from the reported narratives that where examples of good patient-clinician interactions were evident, elements of The Hui Process may have been present, and for those wāhine who did not feel respected or cared for, they may have been absent.

These results may have been impacted by several limitations. We observed equity in terms of access to treatment, with the majority of wāhine interviewed offered a choice of treatments, including the option to undergo breast reconstruction. This may reflect the care provided, suggest engagement with the Hui Process Framework, or be due to broader issues of self-identification when interacting with the health system. The more obscured but broader issue lies with the heterogeneity of Māori self-identification and institutional racism when interacting with health services. Greaves et al. (2015) identified several Māori Identity Signatures that may impact interactions with health services. For example, Māori who physically appear more NZ European (i.e. light skin) may feel protected when engaging with healthcare, while being outwardly perceived as Māori is associated with discrimination (Reid et al. 2016). From this cohort, two wāhine identified as both NZ European and Māori. Due to COVID restrictions, interviews were not held in person, so we could not ascertain whether other wāhine were of lighter skin, which may have contributed to some of the equitable treatment reported. Self-identification and external categorisation, therefore, could be an obscured limitation. Further, there may also be obscured differences relating to the importance of tikanga and its reclamation across age and time. Participants with high levels of cultural efficacy show greater psychological resilience, acknowledging the importance of cultural embeddedness as a protective factor against negative interactions (Muriwai et al. 2015). Anecdotally, it is possible that younger wāhine who have come through Te Kōhanga Reo (Māori Language preschool), Kura Kaupapa Māori (primary school) and Whare Wananga (University) are maturing with stronger Te Ao Māori world views and so react differently to other generations. For example, younger wāhine had stronger views on the inclusion of Te Reo in medical information than some of those in the older age groups. This is an area that might benefit from further research.

Conclusion

This study is significant for many wāhine Māori. We report that the majority of wāhine were engaged in shared decision-making prior to undergoing breast surgery, were offered all surgical options and were satisfied with their surgical outcome. The relationship with their clinician, and in particular the establishment of whakawhanaungatanga was highly valued and provided a basis for positive shared decision-making. Shared decision-making, in turn, enabled a sense of tino rangatiratanga over health decisions and supported wāhine through the decision-making process. Clinicians who take the time to foster positive relationships with Māori translates to overall positive experiences and outcomes for Māori (Graham and Masters-Awatere 2020). While shared decision-making is recommended in clinical practice for BC (Gennari et al. 2021; Mann et al. 2022), it therefore has much wider implications for positive cultural engagement and incorporation of tikanga for Māori diagnosed with BC in NZ.

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Data availability statement

The data generated during and/or analysed during this study are not publicly available due to the sensitivity of patient data but are available from the corresponding author on reasonable request. Ethics approval, participant permissions, and all other relevant approvals were granted for this data sharing.

ORCID

Vanessa Burrett http://orcid.org/0009-0000-2667-0844
Tania Blackmore http://orcid.org/0000-0002-9411-0440
Kimberley Norman http://orcid.org/0000-0003-4278-5451
Karen Turanga http://orcid.org/0000-0001-8558-6861
Ian Campbell http://orcid.org/0000-0003-0882-4138
Ross Lawrenson http://orcid.org/0000-0003-0437-8839

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