

“You receive the diagnosis, but your whānau have the cancer”: patients’ perspectives on breast cancer treatment in Wellington, Aotearoa New Zealand

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ABSTRACT

AIM: This study aims to investigate the perceptions of Māori, Pacific, and non-Māori/Pacific breast cancer patients’ treatment experience in Wellington, Aotearoa New Zealand. It will also explore the support they received throughout their treatment journey and the information provided to them over the course of their care.

METHOD: Qualitative semi-structured focus groups were carried out including breast cancer patients who had completed treatment within the past 2 years. Participants were recruited through breast cancer clinics. Data were analysed using reflexive thematic analysis.

RESULTS: Participants reported a need for more tailored information from health professionals. Many participants reported barriers accessing services and follow-up appointments. Additionally, many participants, especially Māori and Pacific participants, emphasised the importance of ongoing support from healthcare professionals and their personal networks.

CONCLUSION: The findings highlight the need for improving patient-centred communication, recognising the important role of patient support systems and providing more tailored information and resources throughout breast cancer treatment. Addressing these factors could improve different patient groups’ experiences and outcomes by fostering a more informed and supported treatment journey.

Breast cancer is the most common cancer affecting women worldwide, with significant ongoing physical, emotional and social impacts.¹ Advances in surgical and non-surgical treatments have improved survival rates in Aotearoa New Zealand over the past decades, and patients now often undergo many different surgical and non-surgical treatment options, and post-treatment rehabilitation.² Patients are provided with a significant load of information and resources from different specialists and health professionals during their breast cancer treatment. In Aotearoa New Zealand, there is currently no known literature examining the experiences of breast cancer patients in relation to their treatment journey and the information they received during their treatment. Notably, Aotearoa New Zealand has a diverse patient population, including Māori, Pacific, and non-Māori groups; however, recent research has identified that the current surgical evidence base is not responsive to Māori.^{3,4} Therefore, there is a need for research that explores and elevates Māori experiences. Understanding patient experiences is essential for improving patient-centred care,

addressing gaps in service delivery and ensuring equitable access to supportive healthcare interventions. This exploratory qualitative study seeks to generate insights into the treatment experiences of groups often under-represented in surgical and cancer care literature. Small, focussed samples are widely accepted in health equity research to centre voices that may otherwise be excluded from population-level data.^{5,6} In this context, qualitative findings can inform improvements in patient-centred communication, culturally responsive care and service delivery design—especially for Māori and Pacific patients navigating breast cancer treatment in Aotearoa New Zealand. Therefore, this qualitative study aimed to investigate i) breast cancer patients’ perceptions of their treatment, ii) the support they received during their treatment, and iii) the information they received over their treatment.

Method

Study design

This was a qualitative focus group study. The University of Otago Ethics Committee approved

this study (ethics reference code: H23/023). The Interim Research Advisory Group – Māori (IRAG-M #999) also approved this study. Additionally, locality approvals for the different hospitals were obtained for this study. This study took a Kaupapa Māori (Māori-centred) approach, guided by the Te Ara Tika framework for Māori ethical research.⁷ While not a Kaupapa Māori study, Māori values and practices were embedded throughout. The research was developed with Māori and Pacific researchers, included tikanga (Māori customs) (e.g., karakia [prayer], whakawhanaungatanga [relationship building]) and prioritised culturally safe engagement. The study followed principles of whakapapa (genealogy), tika (doing what is right), manaakitanga (care) and mana (authority/dignity). Māori researchers were involved in coding and interpreting data from the Māori focus group.

Participants

Patients were purposively recruited from April 2023 to June 2023 from various breast care centres located in Wellington and Boulcott Hospitals. Patients aged 18 years and older were eligible for this study if they had completed breast cancer treatment, including surgery, in the wider Wellington Region within the past 5 years, either in a private or public setting. The exclusion criteria consisted of people who have undergone breast reconstruction and patients with metastatic disease, as these were considered separate population groups that warrant dedicated investigation. The primary researcher screened the breast clinic list for eligible patients and informed the registered nurse in charge of the clinic for the day. Eligible patients were approached in-person by a registered nurse and informed about the study. If interested, they were provided with the participant information sheet and were also given the opportunity to discuss the study with the primary researcher in a private room or were noted down for the primary researcher to contact later. Completed consent forms were collected before the focus group or interview session.

Data collection

Two focus groups and one interview took place. Participants were grouped by ethnicity to promote cultural safety and depth of kōrero (discussion), although data were analysed together due to the small sample size. Focus Group 1 was face-to-face at the University of Otago (Wellington). Focus Group 2 was a combination of face-to-face at the University of Otago and

over Zoom (Zoom Video Communications, Inc., San Jose, United States of America). The research team was made up of one Tongan (TH), one Irish (EOL), one Māori (WP) and one NZ European researcher (AP). The primary researcher and lead of the project is a Tongan medical doctor (TH). EOL is a female Irish academic physiotherapist, experienced in qualitative research, WP is a male Māori academic physiotherapist, also an experienced qualitative researcher, and AP is a female NZ European breast surgeon. We received extra help from an experienced talanoa researcher (LLT) also to have further talanoa knowledge for the interview. The primary researcher, TH, a Tongan 5th-year female medical student, conducted all discussions, during which field notes were taken. WP was present at the Māori focus group to support the research team with tikanga Māori. The Pacific interview was conducted using the Pacific methodology of talanoa, a traditional approach to revisit knowledge and discussions about a chosen subject within Pacific cultures.⁸ The talanoa was held face-to-face at the participant's home. Three members of the research team were present, including an experienced Pacific researcher (LLT) to support the team and ensure a culturally safe interaction. Audio software Otter.AI (Otter.AI, Mountain View, United States of America) was used to record each discussion. Each session lasted approximately 2 hours. All discussions were conducted using the same protocol and questioning as outlined in Table 1 and Table 2.

The focus group and interview included three questions highlighted in Table 4. These questions were not pilot tested but were discussed and underwent iteration among the research team. The Māori focus group kōrero included revision of the questions with an experienced Māori researcher to ensure that questions were phrased in a culturally safe manner that will be understood by Māori participants. Similarly, for the Pacific talanoa, questions were also revised by an experienced Pacific researcher. Repeating and summarising were used as a form of informal checks during sessions. Transcripts were not returned to the participant, but a one-page result sheet was sent to the participants with an invitation to comment if information discussed was interpreted correctly. No repeat interviews were carried out.

Data analysis

Data analysis was supported by NVivo software (v.14.23.2; NVivo 14. QSR International Pty,

Table 1: Focus group and talanoa protocol.

1	The primary researcher will welcome the participants and whānau by briefly introducing herself and the research team.
2	The primary researcher will lead with a karakia to open the session and bless the kai.
3	The primary research will initiate whakawhanaungatanga and follow by allowing participants and whānau to collect kai or hot drinks and return to their seats.
4	Once participants and whānau are settled and comfortable, the primary researcher will explain the method and outline the flow of the discussion.
5	The primary researcher will outline the purpose of the group and the goals of the meeting.
6	The primary researcher will re-emphasise that the findings will be anonymised. She will also explain that discussion will be audio recorded and transcribed later to writing. This is to ensure that we will not miss anything important from the discussion.
7	The primary researcher will ensure to address any questions and/or concerns that the participants and whānau have before continuing.
8	The primary researcher will discuss the ground rules, and open participation will be encouraged.
9	The first question of the focus group protocol will follow.
10	The primary researcher will give the participants enough time to discuss each question thoroughly until there are no more opinions.
11	The primary researcher will relay the main findings of each question and ask if anyone has anything further to add.
12	Once there are no other questions to ask, and the participants express all opinions, the primary researcher will thank the participants and close the session with a karakia.

Table 2: Focus group and talanoa guiding tailored questions.

	Māori focus group questions	Non-Māori/non-Pacific focus group questions	Pacific talanoa questions
1	What information do you know now that you wished you were informed of earlier during your breast cancer treatment?	What information do you wish you were informed of earlier during your breast cancer treatment?	What are services and initiatives that would have encouraged you during your breast cancer treatment that you felt were not addressed?
2	What kind of support did you have and found helpful during your treatment, i.e., support person or whānau involvement?	What kind of support did you have and found helpful during your treatment, i.e., support person or whānau involvement?	What kind of support did you have and found helpful during your treatment, i.e., support person or whānau involvement?

Table 2 (continued): Focus group and talanoa guiding tailored questions.

3	What were the resources that you utilised and found most helpful during your breast cancer treatment (i.e., patient information sessions, breast cancer foundation website, support group discussions)? What was particularly helpful about those services for you?	What resources did you utilise and find most helpful during your breast cancer treatment (i.e., patient information sessions, breast cancer foundation website, support group discussions)? What was particularly helpful about those services for you?	Were resources and information provided regarding your breast cancer treatment (i.e., patient information sessions, breast cancer foundation website, support group discussions)? What was particularly helpful about those services for you?
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United States of America). Focus groups and interviews were voice recorded and transcribed by the primary researcher. The study utilised Braun and Clarke's six-phase reflexive thematic analysis framework.⁹ An inductive, latent and critically realist approach to the reflexive thematic analysis was used to capture a better understanding of the experience of breast cancer survivors. Using this critical realist approach, the research team focussed on reporting an assumed reality that was evident in the data, i.e., the participants' perceptions of the information they received. However, the analysis also acknowledged the participants' meanings and experiences, and the ways the broader social context interprets those meanings.^{10,11}

The research team reviewed and familiarised themselves with the data, reading and re-reading the transcripts. Subsequently, the primary researcher (TH) carried out reflexive, inductive analysis that informed the codes. This process was repetitive, and codes were revised multiple times. A second researcher (EOL) also coded the data. Furthermore, a third researcher (WP) coded the Māori focus group transcripts. Themes were then established from these codes. All authors discussed the codes, initial interpretation of codes, themes and theme names. This theme construction phase was consultative, with the primary researcher seeking advice from the other researchers in regular weekly meetings to ensure that themes captured the story of the data. The final iterations of thematic construction were carried out by the three non-Māori (one Pacific) team members. We acknowledge this as a limitation.

Results

There were 35 patients who were considered eligible and agreed to be contacted by the primary researcher. There were 28 patients who were not able to participate in the study due to personal

commitments. Many participants cited personal or family commitments, and Pacific women in particular expressed discomfort with group settings. The research team took this into consideration and adjusted accordingly. Overall, seven female patients participated in the study: three participants were included in the Māori focus group discussion, three participants were included in the non-Māori/non-Pacific focus group discussion and there was one Pacific interview (talanoa). The participants were grouped into three separate cohorts (Table 3) by the research team based on their ethnic background. Table 3 describes the participants' demographic details.

Reflexive inductive thematic analysis, using transcripts of discussions from the focus groups and interview, along with comprehensive notes, resulted in three key themes.

For the first theme, "a lack of tailored breast cancer treatment information and guidance for patients", participants described a need for more tailored information and clearer direction of treatment for each individual patient, especially post-surgical treatment. For the second theme, "many barriers to accessing and benefitting from health services", participants conveyed various barriers they encountered to accessing and effectively engaging with health services. They also reflected on their whānau and friends' experiences that influence their interaction with healthcare. For the third theme, "patients and their whānau (family) need a holistic management approach", participants conveyed the importance of understanding the entirety of whānau commitments and responsibilities as part of their breast cancer journey.

A lack of tailored breast cancer treatment information and guidance for patients

The first theme, "a lack of tailored breast cancer treatment information and guidance for patients", reflects participants' reported need for

Table 3: Demographic characteristics of participants.

Grouping	Participants	Ethnicity	Age (years)	Location	Health provider
Focus Group 1	Participant 1	Māori	51	Face-to-face	Private
Focus Group 1	Participant 2	Māori	59	Face-to-face	Private
Focus Group 1	Participant 3	Māori	51	Face-to-face	Public
Focus Group 2	Participant 4	Indian	63	Hybrid: online/ face-to-face	Public
Focus Group 2	Participant 5	NZ European	79	Hybrid: online/ face-to-face	Public
Focus Group 2	Participant 6	NZ European	47	Hybrid: online/ face-to-face	Private
Interview	Participant 7	Samoan	53	Face-to-face	Public

tailored information and reassurance from health professionals at different points of a patient's breast cancer treatment journey to ensure optimum health outcome. In the first sub-theme, "lack of direction and reassurance", participants from the three different sessions highlighted that based on their personal experiences in both the private and public health sectors there was a lack of information addressing the treatment process after diagnosis with breast cancer.

Participants highlighted a dearth of information also preceding the initiation of treatment, specifically concerning the commitment required, work responsibilities and the invasiveness of investigations, i.e., biopsies. Participants conveyed a lack of understanding of the direction and expectations following surgery. They expressed the perception that the information provided was disjointed and inconsistent, contributing to feelings of uncertainty about the trajectory of their treatment. In contrast, in the second sub-theme, "overwhelming information at diagnosis", Māori and Pacific participants conveyed that the information presented during their pre-surgical appointments was overwhelmingly dense, making it challenging to process. In the third sub-theme, "need for tailored information", participants from across the three discussions and, in particular, Māori and Pacific emphasised the need for more tailored information that is staggered and easily digestible for the patient and whānau.

Many barriers to accessing and benefitting from breast cancer services

The second theme, "many barriers to accessing and benefitting from breast cancer services," reflected personal experiences of the participants and their whānau. In the first sub-theme, "barriers to attending appointments", participants emphasised that where post-operative appointments and other services, i.e., cancer support sessions and physiotherapy, were located posed a significant obstacle to utilising them. Therefore, it was difficult to receive the treatment they needed. In the second sub-theme, "barriers to interacting with health services", some participants also reported bad experiences with ringing services when they needed help. These experiences reflect poorly on the health services promised to be available, leading to further mistrust in the health system among minority populations such as Māori and Pacific. One participant also reported being made feel guilty for seeking help as her cancer was not deemed critical. Furthermore, in the third sub-theme, "limitations by pandemic", participants outlined further issues during the COVID-19 pandemic, with family not being allowed to stay as support for ill patients.

Patients and their whānau need a holistic management approach

The third theme was inspired by a very powerful quote from one of the patients: "You receive the diagnosis, but your whānau have cancer."

Table 4: Quotes supporting “a lack of tailored breast cancer treatment information and guidance for patients”.

“Yeah. Well, I didn’t really know what to tell my boss. And I didn’t know what I needed. And I didn’t know what to say. And I didn’t know who to tell or whom not to tell. And it was just a bit like, I don’t really know what to do. Yeah. Yeah.” – Participant 6 (47, F, non-Māori/non-Pacific)

“I kind of found a lot of, uhm I guess, yeah inconsistencies. There were times that I felt like, who do I call [post-surgery]? What do I do?” – Participant 3 (51, F, Māori)

“I’m a verbaliser. I like to be told so I do not need to trickle through a lot of information like I am visual you know. That is how I learn. I am a visual learner.” – Participant 2 (59, F, Māori)

“I made them also print out what they were showing me on the screen, because a lot of the time, we’re looking at the screen.” – Participant 7 (53, F, Pacific)

“Just give me what I need to know now. So, like for this next 2 weeks, you just need to know this booklet here. Don’t worry about the rest of it, because you keep going back to it like what am I meant to do with all of this.” – Participant 1 (51, F, Māori)

Table 5: Quotes supporting “many barriers to accessing and benefitting from breast cancer services”.

“I mean I would have to come all the way to town ... It will take a whole day.” – Participant 3 (51, F, Māori)

“Mine is at Boulcott Hospital and I have to drive from work to Boulcott Hospital and then back to work ... For 3 weeks it was back and forth.” [1 hour total commute] – Participant 6 (47, F, non-Māori/non-Pacific)

“Because I got crook a few times on chemotherapy and have to come into hospital, but even trying to ring, uhm, the ward ... Uhm, it was one night I was it took me 2 hours to get through ... So I am on the phone, coming through into town, trying to ring someone and no one is picking up the phone.” – Participant 3 (51, F, Māori)

“But you[re] constantly being made to feel guilty because you’ve only got a little cancer that’s, you’re one of the lucky ones. But it’s, it’s not look, I’ve still gonna ... do this crap!! [laughter from group].” – Participant 6 (47, F, non-Māori/non-Pacific)

Table 6: Quotes supporting “patients and their whānau need a holistic management approach”.

“I had real troubles with work and like trying to navigate, how to get time off work? How to heal properly and keep your job? ... But it was pretty, that was worse than any of the treatments or anything was not knowing what’s available ... I think I just needed an advocate to help me get time off.” – Participant 6 (47, F, non-Māori/non-Pacific)

“Even knowing that having support for, for families, how to the you know, how, how do they, you know, live with cancers.” Participant 7 (53, F, Pacific)

“And my niece... There’s three. And I just lost my cousin 3 weeks ago.” – Participant 2 (59, F, Māori)

“I was having to take somebody to every appointment because I just go on like. What is going on here and I just sit down. My partner would always say to me, no that’s not what the breast surgeon said. Like you know. Like your head goes somewhere else.” – Participant 2 (59, F, Māori)

“Yeah, well, mum was supportive of me. And, you know ... she keeps away from me when she’s unwell as well ... Uhm I’m not able I’m not well enough to support her fully, but my sister’s there so she’s her main caregiver. And my daughter’s helped out sometimes but, yeah with me, I’m well supported my fam.” – Participant 7 (53, F, Pacific)

Participants reported that when one individual in the whānau is experiencing pain or illness, the whole whānau feel the pain and experience the suffering together with that individual. They often referred to the whānau as the “body”, meaning that if one part of the body, i.e., an arm, is injured, the whole body would feel it. This theme reflects the need for a holistic approach to patients’ management, including their whānau. In the first sub-theme “advocates for optimum quality of life with breast cancer”, participants highlighted that it was crucial to have a support person during appointments. This was especially illustrated by Māori and Pacific participants. Participants emphasised the significance of having an advocate who can provide occupational support alongside managing treatment commitments, as it was unclear when and how they could or should take time off work. The second sub-theme, “whānau support”, outlines how, for many patients, whānau play a major role in providing support throughout the treatment process and offer another perspective on decision making as the diagnosis influences everyone. In the third sub-theme, “support for whānau”, participants underscored the importance of offering support for these carers or extended whānau to help support them living with a person with breast cancer. Additionally, participants described how prevalent breast cancer is in whānau and therefore emphasised the importance of a whānau-based approach to breast cancer treatment.

Discussion

A lack of tailored breast cancer treatment information and guidance for patients

The first theme, “a lack of tailored breast cancer treatment information and guidance for patients”, was consistent between the three sessions. Participants highlighted a dearth of information preceding treatment, specifically concerning the commitment required by patients, how to handle work responsibilities and the invasiveness of upcoming investigations, i.e., biopsies. Consequently, this lack of clarity left participants feeling lost and lacking direction regarding what to expect in the post-surgical phase of intervention. This was reported by participants who received their breast cancer surgery in the private health sector as well as the public health sector. They expressed the perception that the information provided was disjointed and inconsistent, contributing to feelings of uncertainty

about the trajectory of their treatment. Previous research has identified that breast cancer patients in Aotearoa New Zealand 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.¹² They reported how this shock impacted their ability to retain the diagnostic information presented to them. This inability to retain this information may explain the perceived dearth of information participants in this study reported. However, other international studies have previously documented that patients perceived their perioperative information as insufficient and poorly timed.¹³ The recurrence of these themes in past literature underscores the necessity for innovative methods to enhance healthcare accessibility.

In contrast, some participants conveyed that the information presented during appointments was overwhelmingly dense, making it challenging to process. Māori and Pacific participants emphasised the significance of incorporating visual tools alongside verbal information to facilitate their comprehension of treatment-related information. This has been noted in previous research that investigated wāhine (women) Māori with breast cancer, who expressed a lack of clear, culturally relevant guidance at key points in their treatment journey and recommended a multi-modal presentation of medical information, with inclusion of te reo Māori.¹¹ Ultimately, these findings reinforce the value of redesigning breast cancer information in Aotearoa New Zealand using co-design approaches that reflect the needs and realities of our diverse population.

Many barriers to accessing and benefitting from health services

Participants reflected on personal experiences and those of their whānau to identify barriers that they encountered in accessing and benefitting from breast cancer services. Participants emphasised that the location where services and appointment locations were offered posed a significant obstacle to utilising them. Barriers to healthcare access for Māori and Pacific patients in Aotearoa New Zealand are well documented and include institutional racism, geographic and financial challenges and distrust in services due to historical and ongoing inequities.^{14,15} Our study findings reflect many of these broader systemic issues, with participants describing logistical difficulties, emotional burdens and fragmented support

systems. However, this study uniquely captures participants' emotional tolls and sense of abandonment that results from insufficient follow-up and lack of guidance post-surgery. These experiences of being unsure who to contact, or feeling guilty for seeking help, reflect the relational harms that can occur when healthcare systems fail to deliver culturally safe, responsive care. It would also seem to lead to further mistrust in the health system among minority populations such as Māori and Pacific.¹⁶ For example, some participants found it quite frustrating and frightening to reach out to services instructed to be contacted in case of concerns, such as calling the emergency department if they developed a fever while on chemotherapy. One participant expressed feeling guilty for seeking help as her cancer was not deemed urgent by health professionals. These insights expand current understandings of how cultural safety and health equity must be embedded not just in access and during the surgical cancer journey, but in every stage of care delivery. This also underscores a need for ongoing investment and training in relationship-centred models of care.

Patients and their whānau need a holistic management approach

The third theme outlines when one individual in the whānau is experiencing pain or illness, the whole whānau feel the pain and experience the suffering together with that individual. Previous research noted that excessive focus on viewing the patient solely as a “site of disease” with an overemphasis on risk management can undermine holistic, patient-centred perspectives and can diminish the effectiveness of crucial non-medical aspects associated with patient care.¹⁷ The need for holistic, whānau-inclusive cancer care in Aotearoa New Zealand has been articulated in many studies.^{18,19} However, our study results outline how it remains inconsistently embedded in practice. Our findings are a reminder that for many families, including Māori and Pacific families, illness is a shared experience, and that treatment and care planning must reflect this reality.

Similarly, participants expressed a need for advocates to aid patients with their personal responsibilities, which were in addition to commitments associated with treatment. One participant emphasised the importance of having an advocate who could provide support with respect to employment-related issues alongside the management of treatment-related commitments. This

included factors such as sick leave entitlements, the physical demands of their job and flexibility of employment to work from home. Previous research has described significant employment rate reductions, income support increases and income losses in the 4 years after first breast cancer diagnosis in Aotearoa New Zealand.²⁰ This is also an issue of equity for Māori, Pacific and lower socio-economic status patients who are more likely to work in the construction and service industries.^{21,22} These women may also have responsibilities for their children, whānau and community. Therefore, it is vital to investigate thoroughly in a respectful and non-judgemental manner the circumstances of each patient. Here, this study adds nuance by illustrating that economic dimensions of post-treatment recovery are an important part of the treatment process for patients in the healthcare system—especially for women balancing caregiving and employment. This study supports that healthcare or associated services must consider return-to-work planning and financial navigation as core components of care, especially when caring for patients facing structural disadvantage.

Additionally, some participants underscored the importance of the offer of support due to high prevalence of disease within the whānau. This is a critical observation, given that for numerous patients, their whānau plays a major role in the provision of support throughout the treatment process. Whānau also provide another perspective regarding treatment and disease-related decision making. Previous research has shown that whānau involvement is central to culturally responsive cancer care in Aotearoa New Zealand. For example, previous research highlighted the critical role Māori health providers play in supporting whānau across the cancer continuum—offering not only clinical navigation but also transport, advocacy and emotional support through family-based care rather than individual-based care.¹⁹ While their work focusses on the delivery of services from the provider perspective, our study adds the lived experiences of wāhine Māori, Pacific, and non-Māori/Pacific breast cancer survivors themselves. More broadly, in stroke patients, rehabilitation sessions including family members significantly enhanced outcomes when compared to those without family involvement.²³ The authors also suggested that caregiver strain reduced with family participation in patient care, and additional family support led to increased social activities and improved quality of life for

all parties involved. These findings suggest that similar approaches in cancer care—where whānau are included and supported throughout the treatment journey—may improve both patient and family outcomes.

Implications for equity and health system improvement

These findings reflect wider systemic barriers that contribute to health inequities for Māori and Pacific women undergoing breast cancer treatment. In line with Te Tiriti o Waitangi and the *Pae Ora (Healthy Futures) Act*, this study underscores the need for culturally responsive care that recognises the collective experience of whānau, the importance of clear and tailored communication and the logistical barriers that affect access to services.^{24,25} These issues mirror known inequities outlined in the Waitangi Tribunal's Health Service and Outcomes Inquiry (Wai 2575) and highlight opportunities to improve cancer care pathways in Aotearoa New Zealand.²⁶

The findings also align with the goals of the Women's Health Strategy 2023, which calls for health services that are more equitable, whānau-centred and responsive to the needs of wāhine Māori and Pacific women.²⁷ In particular, the strategy highlights the importance of providing health information that is culturally appropriate, accessible and co-designed with communities. Our participants' experiences reinforce these priorities and point to practical improvements, including the redesign of post-operative information materials, development of whānau-inclusive models of patient education and more culturally responsive service planning. While based on a small sample, the study contributes meaningful, patient-led insights to support breast cancer care in Aotearoa New Zealand.

Strength and limitations

This study included patients from various ethnic backgrounds and categorised them into different groups based on ethnicity. This approach offered a platform for Māori, Pacific, and non-Māori to precisely express their individual healthcare needs and explore effective ways to address these needs in the future. Although the sample is small, the study prioritised depth over breadth to understand culturally specific experiences that are often under-represented in surgical literature. We considered sample

adequacy through the lens of information power, where smaller samples may be sufficient if the data are rich and focussed, and the aim is narrow.²⁸ Given the specific focus of our study, participant specificity and high-quality dialogue, our sample was deemed appropriate to address the research aims.

However, the study was conducted solely in the Wellington Region, with a modest number of participants; therefore, the data are limited in their interpretation and may not be extrapolated to fully represent healthcare needs throughout Aotearoa New Zealand, such as women in rural settings. Also, there was only one Pacific participant (Samoan). This participant's viewpoints are not representative of the whole Pacific population, who make up 6.9% of the overall population of Aotearoa New Zealand.²¹ This includes a combination of ethnic groups, including but not limited to Samoan, Tongan and Cook Islander. Furthermore, participants were not explicitly asked to describe aspects of their breast cancer care that worked well, which may have limited insights into strengths or successful components of current services. Finally, this study was not conducted under a Kaupapa Māori research framework. We acknowledge that Kaupapa Māori research centres Māori ways of knowing, tino rangatiratanga (self-determination) and Māori leadership at every stage.²⁹ Conducting research with Māori outside such a framework poses risks—such as reinforcing power imbalances, limiting cultural safety, marginalising Indigenous knowledge and misinterpreting data.³⁰ To mitigate these risks, this study was developed by a team that included one Māori researcher, incorporated tikanga Māori processes such as karakia and whakawhanaungatanga and involved Māori input in data interpretation. However, we recognise these efforts do not fully address the limitations of working outside a Kaupapa Māori approach.

Conclusion

This qualitative study aimed to explore breast cancer patients' perceptions of their treatment, the information received during their treatment and the support received during their treatment. It investigated preferred resources and perceptions of healthcare providers and emphasised the importance of involving family—“*You receive the diagnosis, but your whānau have the cancer.*” This study identified a need for tailored information

relevant to the specific population groups and a need to be holistic when considering patient management approaches. The study also identified barriers to accessing health services

in local communities. These findings hope to influence health strategies to support various breast cancer patient groups.

COMPETING INTERESTS

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