Māori clinical leadership: Driving improvement in Māori health

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ABSTRACT

He mea nui te hautūtanga Māori hei whakawhānui, hei pupuri hoki i ngā kaimahi taketake i te rāngai, hei whanake i ngā wheako o te hunga Māori ka whiwhi taurimatanga ā-hauora, hei tutuki hoki i te mana taurite me te oranga o te hauora Māori. He mahi nui tā ngā mātanga haumanu Māori i te āhua ki te whakarite taurimatanga me te whanaketanga o ngā ratonga mō te hunga Māori ka whātoro ki te taurimatanga i ngā rōpū whakahaere hauora Pākehā a te Karauna. Kei te piki te kiteatanga me te whakamātāmuatanga o te hautūtanga Māori i ngā pūrongo hauora matatau, engari he iti tonu te hunga kei roto i te rāngai mahi hauora Māori.

I aro tēnei rangahau ki te mātauranga me te tirohanga kaupapa Māori hei tātari i te ara tika hei tautoko i ngā mātanga haumanu Māori e puāwai ai rātou i roto i ngā rōpū whakahaere hauora a te Karauna. Mā roto mai i ngā pūrākau a ngā mātanga haumanu Māori, ka whakaatu tēnei rangahau i te whānuitanga o ngā mahi a ngā mātanga haumanu Māori, me te whakatakoto tūtohitanga hei whanake i ngā āhuatanga kia puāwai.

Tekau mā rua ngā mātanga haumanu Māori i ngā rāngai rata, tapuhi, oranga hoki, i tonoa. I pōhiritia rātou katoa ki te tuari i ā rātou pūrākau. I whakamahia tētahi anga pūrākau hei tātari i ngā raraunga kia puta mai ko tētahi pūrākau.

E toru ngā kaupapa matua i puta: tūāpapa hautūtanga, whakamana me te whakapau kaha, te manawa tītī. Ka aro te kaupapa tuatahi, te tūāpapa hautūtanga, ki tō ngā whakaaro o ngā kaikōrero ki te pānga o te ahurea ki te hautūtanga. I whakatairanga ngā mātanga haumanu Māori i te hirahiratanga o te pono me te whakamārama i ā rātou mahi whakapakari i te tūāpapa hautūtanga. Ka aro te kaupapa tuarua, te whakamana, ki te awhi me te tautoko. Ka whakatairanga i te hirahiratanga o te tautoko me te ārahi i ngā mātanga haumanu Māori, nā ngā mātanga haumanu Māori hoki. Ka whakaatu te kaupapa whakamutunga, te whakapau kaha, te manawa tītī, i te ū a ngā mātanga haumanu Māori ki te turaki i ngā wero kia pakari ake.

Ka whakaatu tēnei rangahau i te mana o ngā mātanga haumanu Māori i roto i ngā taiao haumanu, e whakaū nei i ō rātou pūkenga me te āhei ki te whai pānga i roto i ngā mahi me ngā ratonga haumanu. Ka whakatairanga i te aro ki te hautūtanga haumanu Māori i te whānuitanga o ngā rāngai hei whakanui i te kiteatanga me te tautoko, e hāngai ana ki ngā ūara Māori whakakotahitanga. Ko ngā painga hautūtanga haumanu Māori ko te whakapapa, ngā ūara ōrite i te ao Māori, te ū ki te whakawhanake, me te tuitui i ngā tikanga i roto i ngā horopaki haumanu hei painga mō te hunga ka whātoro ki te haumanutanga.

Ko tētahi o ngā tūtohitanga ko te poipoi i te whai wāhitanga me te tuakiritanga hei mātanga haumanu Māori mā roto mai i ngā hononga, te whakaako me te tautoko i ngā whakangungutanga ara-rua ka whakakaha i ngā pūkenga ahurea me ngā pūkenga haumanu. Me whakakaha i te mātaitanga o ngā mahi a ngā rōpū whakahaere a te Karauna hei whanake i te rāngai hauora Māori mā te whakawhānui i te tikanga o te hautūtanga i roto i ngā kaupapa here. He kōrero i roto i tēnei rangahau mō te tikanga o te puāwaitanga o ngā wheako tautoko, whakamana, whakatairanga hoki o ngā mātanga haumanu Māori.

Māori leadership in health is essential to expand and retain an Indigenous workforce, improve the experience of Māori receiving healthcare and to achieve Māori health equity and wellbeing. Māori clinical leaders play an important role in the direct provision of care and improvement of services for Māori accessing care in western dominant Crown health organisations. There is growing recognition and prioritisation of Māori leadership in high level health reports, however Māori health workforce numbers remain low.

This research utilised kaupapa Māori knowledge and perspectives to investigate how Māori clinical leaders should be supported to thrive in Crown health organisations. Through the pūrākau of Māori clinical leaders this study illuminates the full scope of Māori clinical leadership work and makes recommendations for improvement that will create environments of thriving.

Twelve Māori clinical leaders from medical, nursing and allied health professions were purposively recruited. Each participant was invited to share their pūrākau through unstructured kōrero. Data analysis utilised a pūrākau framework to articulate a collective pūrākau.

Three main themes were generated: Foundations for leadership, whakamana, and grit and determination. Foundations for leadership, delves into participants' perceptions of how culture influences leadership. Participants emphasised the importance of authenticity and described the ways in which they strengthen their leadership foundations. Whakamana, encompasses the subthemes of awhi and tautoko. It highlights the importance of support and mentoring for and from Māori clinical leaders. Grit and determination, illustrates the resilience of Māori clinical leaders in overcoming obstacles to emerge stronger.

This study demonstrates that Māori clinical leaders have power in clinical environments, reinforcing their technical expertise and their ability to affect change in clinical practice and for service delivery. It advocates for viewing Māori clinical leadership broadly across professions to enhance collective influence. Māori clinical leadership strengths include foundations in whakapapa, shared values in te ao Māori, a commitment to creating change, and the integration of cultural practices in clinical settings for the benefit of those accessing care.

Recommendations include fostering a sense of self-identity through connection and both cultural and clinical development. Monitoring activity to hold Crown health organisations accountable for the growth of the Māori health workforce should be strengthened by expanding on definitions of leadership in policy. This study provides an evidence base around what constitutes as thriving to tautoko, uplift and illuminate experiences of Māori clinical leaders.

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools, nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature:

Tracy Murphy

Date: 19 June 2024

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He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata.

This study was approved by the Auckland University of Technology Ethics Committee on the 15th of November 2022. AUTEC reference number 22/299.

INTRODUCTION

An overview of the problem

The public health system in New Zealand provides inequitable access to interventions and quality of care for Māori patients, who also experience the worst health outcomes of any population in New Zealand (Came, 2014; Espiner et al., 2021; Graham & Masters-Awatere, 2020; Harris et al., 2019; Reid, 2021; Waitangi Tribunal, 2019; Wilson & Barton, 2012). However, it is not only Māori accessing healthcare who feel alienated and marginalised. There is strong evidence that Māori employed within publicly funded healthcare systems in Aotearoa can feel like foreigners themselves, experiencing microaggressions, discrimination and "sustained cultural dissonance" which results in difficulties retaining Māori staff (Hunter & Cook, 2020, p. 7; Wilson, Barton, & Tipa, 2022). There are reports of Māori healthcare professionals feeling a weight of expectation from their non-Māori colleagues, a constant need to challenge the system, and personal and community expectations of being a voice for change, all in the face of routinely coping with racism (Hunter, 2019; Hunter & Cook, 2020; Huria et al., 2014; Jones et al., 2019; Sampson, 2019; Tipene, 2017; Wilson, Barton, & Tipa, 2022). It is well established that the Māori health workforce is essential for the delivery of safe and equitable health care for Māori populations (Davis & Came, 2022; Hunter & Cook, 2020; Ministry of Health, 2020b).

Violette et al. (2021) identified the Indigenous health workforce as a cornerstone to "providing culturally safe primary health care for Indigenous peoples and communities" (Violette et al., 2021, p. 3175). Increasing the numbers of Māori health professionals is one recognised way of improving Māori access to and experience of health services (Huria et al., 2014). Decolonisation of healthcare will not be achievable unless we are able to keep Māori employed and working in Crown health organisations (Came, Warbrick, et al., 2020).

Māori leadership has been identified as a vital part of the healthcare system in Aotearoa. The Simpson Review identified Māori leadership and control over the use and application of mātauranga Māori in contemporary health settings as critical to the improvement of Māori health outcomes (Health and Disability System Review, 2018). Hauora Māori strategies since 2014 have explicitly prioritised Māori leadership at all levels of the health system to enable Māori health equity (Minister of Health, 2023; Ministry of Health, 2014, 2020b) and Te Pae Tata: Interim Health Plan promised to embed Te Tiriti o Waitangi by growing Māori leadership, workforce and services (Te Aka Whai Ora - Māori Health Authority & Te Whatu Ora - Health New Zealand, 2022, p. 6).

This growing recognition and prioritisation in national reports and strategies is important. However, in practice low numbers of Māori are part of the healthcare workforce and this likely reflects their

experiences of working in environments with racism and alienation as described above. The Health Workforce Plan 2023/2024 estimated that only 9% of the Te Whatu Ora, Health New Zealand workforce was Māori and did not provide any figures on numbers of Māori in leadership, noting a lack of cohesive data across Aotearoa (Te Whatu Ora - Health New Zealand, 2023). Quarterly reporting on the Health New Zealand workforce provides a number of different interpretations of data including ethnicity information by district and length of service, but does not report on leadership (Health New Zealand Te Whatu Ora, 2023).

A common gap across national policy and strategic documents is a description or acknowledgement of what Māori leadership is. Personal experience suggests that Māori leadership in Crown health organisations is much bigger than a typical people management job title such as team leader, duty nurse manager, professional leader, chair and so on. I have been continually amazed witnessing the strength and determination of Māori in our organisation who devote so much of themselves to their work and are often unrecognised. I have observed that they frequently dedicate much of their own time to ensure that they are the best that they can be for their people and frequently take on tasks outside of their usual role expectations that they are not remunerated for. A perfect example of this is a previous colleague in their first two years of practice, who was providing education sessions for 70+ staff members to increase the cultural safety of the inpatient allied health service, while working fulltime and completing a diploma in te reo Māori. Many examples like this, alongside the rhetoric of Tauiwi allies lamenting the high turnover of Māori staff: "I can recruit them, why don't they stay?" has led me to this research. Subsequent chapters will fully identify and describe the research gap specific to leadership provided by Māori clinicians.

The question and aims

The overarching question that this research will address, is "how should Māori clinical leaders be supported to thrive in Crown health organisations in Aotearoa?". This research aims to bring about transformative change through in depth understanding of the current context, articulation of the full scope of Māori clinical leadership work and provision of recommendations for improvement based on the pūrākau of Māori clinical leaders.

An overview of the approach

This research utilises kaupapa Māori, an Indigenous paradigm chosen to recognise the legitimacy of Māori knowledge, to guide and inform the approach to research and to ensure culturally relevant interpretation of findings (Pihama, 2010; Smith, 2012). The umbrella of kaupapa Māori encompasses a number of concepts including philosophy, theory, methodology and practice of research (Health Research Council of New Zealand, 2010). For this research, I have taken a critical theory perspective, which will be explored further in the research design chapter. Kaupapa Māori research from a critical

theory perspective aims to provide a platform from which Māori can illuminate and change the unequal power relations inherent in New Zealand systems (Eketone, 2008; Mahuika, 2017; Pihama, 2010; Smith et al., 2012). This perspective will give strength to the research question "How should Māori clinical leaders be supported to thrive in Crown health organisations in Aotearoa?". My approach to research design has been developed and refined in part through a purposeful use of reflexivity and critical reflection. This is demonstrated throughout the thesis through use of 'whaiwhakaaro' text boxes. These whaiwhakaaro represent extracts from my reflexive journal, which examines my personal values, assumptions, and experiences, critically reviewing the impact these may have on my research. The importance of reflexivity is touched on as I describe who I am and in further detail in the research design chapter.

Māori clinical leaders were invited to share their knowledge and experiences through unstructured pūrākau. Pūrākau has been used in this research in two ways. Firstly, as an Indigenous storytelling approach, providing the opportunity to explore Māori clinical leadership, and secondly as a framework for undertaking data analysis. Pū-rā-kau analysis takes the separate components of the kupu pūrākau, utilising them as a framework to uncover meaning from an Indigenous perspective. Using pūrākau interpretation of Māori clinical leaders' stories, this research presents a collective story, explores new knowledge and develops key recommendations to contribute towards enabling the aspirations of Māori clinical leaders.

Setting the scope of this project

While Māori leadership is something to be celebrated across disciplines and in all areas of mahi, it has been necessary within this professional doctorate research to set clear boundaries in order to establish an achievable scope. This research specifically targets Māori *clinical* leadership, and leadership in health, with the reasons for this explored as this thesis progresses. Within the sphere of western leadership there are numerous writings, models and frameworks, and many of these will be touched on, however they are not the focus. Outside of the scope of this research is the contribution of colleagues working in areas such as education, climate change, justice, and business leadership, along with the mahi of Indigenous leadership outside of Aotearoa. Rather, the focus of this research is Māori clinical leadership in Crown health organisations in Aotearoa, with both of these concepts defined below.

Thesis structure

This introduction chapter has started with a succinct outline of what led me to this research and why I believe it to be important. I have identified the research question and indicated the approaches that will be utilised in this study. The following paragraphs will outline each chapter to present the structure of this thesis and provide further overview.

Background

In the background chapter I will describe who I am and my whakapapa, to position myself within the research context. I will also highlight the privilege that te reo Māori deserves within my research and introduce key terms and phrases. This chapter illuminates the historical contexts relevant to this research and the impact these have on the contemporary health landscape for kaimahi Māori. I describe the historical and ongoing importance of Te Tiriti o Waitangi to health, connecting and bringing together pivotal concepts such as colonisation and racism with current healthcare contexts. I discuss experiences of Māori in the health system and elaborate on the national strategies and policies that emphasise the importance of Māori leadership. These factors together set a scene that establishes Māori clinical leadership as an essential factor in future improvements to the health and wellbeing of Māori.

Literature review

This chapter presents a systematic literature review with a specific scope that delves deeper into what is currently known about Māori leadership in health. Literature including peer reviewed articles and theses were analysed, with three key themes identified: Māori values demonstrated in leadership; Māori leadership to provoke change; and advancing Māori leadership. This review evidences the growing body of research into Māori leadership in health, and the absence of knowledge about Māori clinical leadership specifically.

Research Design

The research design chapter describes kaupapa Māori philosophy and kaupapa Māori research based in localised critical theory, prior to delving into kaupapa Māori methodology, distinct (but not separate) to its philosophical foundation. I present an illustration that provides an overview of the research structure and describes a systematic approach to what can be very complex and interdependent concepts. Within the research design I describe how pūrākau is used in Indigenous research and go into detail about how participants shared their pūrākau. Finally, this chapter will describe my analysis approach, which utilises complimentary approaches of pūrākau framework and reflexive thematic analysis.

Findings

Presentation of the findings begins with a description of the context that Māori clinical leaders are working in. This clearly identifies racism and the impact of colonisation for Māori clinical leaders, setting these factors apart from themes that add to mātauranga on Māori leadership. The findings chapter goes on to describe three themes under the pūrākau data analysis framework: Foundations

for leadership; whakamana; and grit and determination. The voices of Māori clinical leaders are taonga, therefore their kōrero is the key focus of the findings chapter.

Discussion

I begin the discussion chapter by reviewing the question and aims that this research started out to address. This chapter highlights new mātauranga, weaving this together with the existing kete of knowledge about Māori leadership in health to present key concepts derived from this research. I present an argument for a collective view of Māori leadership in health and explore the power of the clinical context. This discussion draws on some broader literature on Māori workforce to strengthen knowledge specifically about leadership. Perceptions of the foundations of Māori clinical leadership are explored and an argument for building layers that strengthen leadership are presented. Finally, Māori clinical leadership is presented as a tool for decolonisation and whakatika. Recommendations for change to practice are made throughout this chapter.

Conclusion

The conclusion chapter lists key recommendations, linked directly to factors that support Māori clinical leaders to thrive. The implications of this research on practice for Māori clinical leaders is discussed and the limitations of the research considered.

Kupu Whakatepe

The kupu whakatepe at the end of each chapter provides a summary of what has been discussed and briefly introduces what will follow in the following chapter. This introduction chapter has set out an overview of the problem, outlining what led me to this research. I introduced kaupapa Māori research as the approach to address my research question and provided an overview of the approach.

The following background chapter goes into more detail about who I am and my position in this research. It offers some key definitions before identifying why Māori clinical leadership is important and presents historical information that sets the scene for the current environment that Māori clinical leaders work in.

BACKGROUND

This chapter establishes both my whakapapa as the researcher and the whakapapa of Māori clinical leadership. I introduce myself, my position in this research and establish the importance of te reo Māori in this work. I provide descriptions of key terms and introduce key historical information that continues to impact the contemporary health landscape in Aotearoa. The chapter concludes by critically examining national healthcare strategy and policy in relation to leadership, positioning Māori clinical leadership as a key factor in future improvements in the health and wellbeing of Māori.

> *"In order to understand where one wants to go, one must first understand where one has come from" (Tiakiwai, 2017, p. 79).*

Ko wai au?

Ko Te Ahuahu te maunga

Ko Omapere te roto

Ko Waitangi te awa

Ko Ngātokimatawhaora te waka

Ko Ngāpuhi tōku iwi

Ko Ngati Hineira me Te Uri Taniwha ōku hapu

Ko Parawhenua, Rawhitiroa, me Ngāwhā ōku marae

Mark Swinburne tōku pāpā

Jacquie Kidd tōku whaea

Ko Tracy Murphy ahau

Positionality is important in kaupapa Māori research, both in determining who is carrying out research, why and for who, but also in ensuring that those reading my work know who I am and where I come from. Although I have been able to recite my pepeha for a number of years, recently I have become more conscious of my struggle to make connections during whanaungatanga. With the support of my teina our whānau are growing our connections to home and I have begun to slowly expand my knowledge. The following paragraph is written with her support.

Rāhiri is the tūpuna of Ngāpuhi. He had two sons, and we come from Uenuku-kuare. Our hapū Ngati Hineira was named after an ancestor Hineira, approximately 11 generations back from us. Ngati Hineira was established as we know it today in the early-mid 1700s. The key point for our whānau is our four times great grandmother Erana Kareariki, daughter of Pehiriri and Kuki. Erana lived in the

early 1820s to early 1870s, firmly in Te Tiriti o Waitangi times. She was the first in our line to marry and have children with a Pākehā, Arthur (Aata) Edmonds. One of their children was Ruiha Edmonds, who married Samuel Calkin (another Pākehā). Ruiha and Samuel were the first to move South, moving to Whangārei in 1889. Their eldest son was Pierre Calkin, our Great-Grandmother's Father. Great-Grandma (Tirohia) was the last generation to speak te reo Māori, choosing not to pass it on to her children.

An aspect of positioning who I am in this research is identifying where my current knowledge base sits and where my learning has come from. Linda Tuhiwai-Smith (2012) identified that within the ranks of Indigenous researchers is a number of those who identify themselves as Indigenous despite their research education sitting predominantly within "Western academy" (p. 5). This statement acts as a reminder for myself as a novice kaupapa Māori researcher: prompting me to consider what influences my research and analysis processes. This doctoral journey represents my first foray into true kaupapa Māori research. Although occupational therapy represents a philosophy of holistic and person-centred care, my degree and subsequent post-graduate studies were very western driven.

My position in this research has numerous perspectives. I am someone who identifies as Māori with whakapapa to Ngāpuhi, I have worked within a non-Māori team in a Crown health organisation, experienced racism, fought for the best possible care for patients and worked to improve the knowledge and cultural safety abilities of those around me. All of these positions have an influence on this research and have been explored as a part of demonstrating reflexivity, or engagement in self-reflection about the biases, values and experiences that I bring to the research (Creswell & Poth, 2018; Kwame, 2017). Sharing myself within this research process has required a mind shift, challenging the teachings I have had as a clinician not to share details about yourself. For example as a new graduate starting my career in a hospital, I was advised not to have my first and last name printed on my brand-new hospital name badge and not to let patients know where I lived despite wanting to know every minute detail about their lives. This mimics early research experiences, where my focus was heavily on minimising bias and attempting to keep myself separate from participants as the researcher.

Kaupapa Māori refers to Māori ways of being and incorporates the notion of Māori being free to be Māori in contrast to being the 'other' (Henry & Pene, 2001; Smith, 2012). Tiakiwai (2017) however, identified 'being Māori' as vague in the context that Māori can be many things. Other authors agree, noting that Māori are not homogenous and along with differences between iwi, hapū and whānau there are also differences in strength of connection to te ao Māori, and differences in understanding of what being Māori means (Mahuika, 2017; G. Smith, 2017; Te Huia, 2015; Tipa, 2021). Smith (2012)

acknowledged this perfectly, noting the pervasive belief that "Indigenous cultures can't be complicated, internally diverse or contradictory, only the west has that privilege" (p 77). Because of colonisation I am discovering my Māori culture, whakapapa and te reo as an adult. Although this feels like it is a point of difference for me, I know that I am not alone in this. The reflection of a kaupapa Māori researcher Mitchell (2011) has resonated with me in considering my position:

> *"To me, plain and simple, the (un) in (un)comfort is about the level of te reo and tikanga I don't think I have. Is this of my own choosing? Well, no, it isn't. The (un) in (un)comfort signifies the difficulties of learning te reo me ona tikanga for a whole lot of Māori people and for a whole lot of reasons. The (un) in (un)comfort also asks hard questions about what it means to be Māori in the 21st century, with so many Māori not being native or fluent speakers of te reo Māori." (Mitchell, 2011, p. 59).*

Hearing about (un)comfort from a kaupapa Māori researcher provided me with the confidence to move forward despite all the learning still to be done. Acknowledging my own (un)comfort is an essential part of who I am and opens opportunities for learning and growth. Reinforcing that this acknowledgement is important, Smith (2012) noted that for some Indigenous students one of the first issues to be confronted is their own identity as Indigenous. She described interconnected identities and reflected on students questioning what an authentic Indigenous person looks like and what criteria might be used to assess the attributes that might qualify someone as authentic. These are all questions that acknowledging (un)comfort can support.

I am a daughter and a mother, wahine Māori, an occupational therapist, and an employee of a Crown health organisation in Aotearoa. I have my own experiences of giving more than my clinical role demands, of being the one who is called on for karakia while at the same time being overlooked for contributions because of my blond hair and blue eyes, and of the exhaustion of trying to learn my language in evenings and weekends. My tamahine and I have all the privileges of being socially assigned as white. I have held a variety of formal leadership titles in a career that has involved working primarily on a hospital campus. All my academic learning and leadership training has been through "mainstream" education providers. I acknowledge that all these perspectives have had the potential to influence this research and committed to understanding this influence in order to accurately position myself.

Research whānau

When I first started this journey, I had read in other kaupapa Māori research about the research village or whānau. These seemed to be formal in their setup and use, with meetings and kai and feedback. I was envious reading these examples, however, I have realised during my own journey

that I have my own large research whānau. It might not be particularly formalised, has ebbed and flowed, but it has been just as powerful and has had a huge influence on my work. It is worth noting that my research whānau is not solely made up of Māori, but also includes Tauiwi allies.

Research whānau is a concept that has become part of kaupapa Māori methodology for a number of reasons, including giving voice to a collective, inclusivity of different Māori perspectives and a way to deliberate on ideas and issues (Smith, 2012).

The influence of my research whānau started in the early planning stages, where I was attempting to define my question and the focus of my research to ensure it was relevant, appropriate and of benefit to Māori. I received support from other researchers who were willing to discuss their techniques and approaches with me. My research whānau was active during the recruitment of research participants and made the chosen recruitment technique of snowballing very effective. They have listened to discussion on analysis, supported reflection and have been willing to provide challenge or tautoko and awhi depending on what was required. At different points throughout this thesis as appropriate, this research whānau will be referenced. The use of a research whānau as a method of reflexivity in insider research is explored further in the research design chapter.

Privileging te reo Māori

Using te reo Māori is essential to retain mātauranga Māori and is a key component of kaupapa Māori research (Smith, 2012). Within this research te reo Māori is privileged in a number of ways: Through recognition of te reo Māori as a foundational principle in kaupapa Māori research; by using te reo Māori throughout this research; and through the normalisation of te reo Māori by not providing direct translations for commonly used kupu. Te reo Māori as a foundational principle in kaupapa Māori research is explored from a more academic perspective in the research design chapter. This section flows from my description of positionality and focused on pivotal moments that led to key decisions, such as not translating te reo Māori kupu.

Te reo Māori is an official language of Aotearoa (Māori Language Act, 1987) but has been under threat of complete loss (L. T. Smith, 2017). From the earliest days of colonisation, mission schools were used to teach English. In 1910, 90% of children were recorded as te reo Māori speakers, by 1953 this had declined sharply to 26% and by 1970 only 5% of Māori children could speak their language (Benton, 2015). It was predicted that once the generation of kaumātua had passed on, te reo Māori would no longer have native speakers (Ministry of Māori Development, 2003).

The first pivotal moment for me humanises the bleak statistics above that describe the decline of te reo Māori speakers in Aotearoa. During a noho marae for a beginners te reo Māori class that I completed, a classmate shared her vivid recollection of being hit at school for speaking te reo Māori.

She cried as she described being a young Māmā and her resolve that her own children should never speak te reo Māori at home. She shared her pride for her mokopuna who were at kura kaupapa and kohanga reo. She was coming to class so she could understand what they were saying and did not have to ask them to speak te reo Pākehā. Even though I knew how important the restoration of te reo Māori is, this beautiful Nanny illuminated the issue with such bravery that she brought the issue into a new light.

During the planning phases of this research, I had been offering definitions of te reo Māori in my writing by following kupu Māori with their translation in te reo Pākehā (usually in brackets). I was doing this although I knew that for every kupu Māori, there is a depth of history and meaning to a word that is difficult to capture in one-word translations. During my literature search I came across an author who referred to 'touchpoints' rather than direct translations. Haar et al. (2019) outlined Māori values in leadership and noted during this that it is impossible to translate a Māori value with all its history and variety of applications into one English word. Instead, they referred to the translations as touchpoints, or areas of commonality. This seemed more appropriate, but still not quite enough. It was not until I read a thesis written by a colleague that I questioned why I felt the need to provide translations at all. Tofi (2022) described the decision not to define the te reo Māori kupu or Samoan language he used throughout his research as a way to celebrate and elevate Indigenous languages. He warmly encouraged readers to take the time to seek out new knowledge should they come across a new word or a phrase, pointing out that language dictionaries are easily accessible through numerous channels such as apps on a phone, or even google. In earlier work Cram (2001) argued directly against translations of te reo Māori to English in writing and research, noting the "inadequacy of the English language to communicate the full intention of what we want to say" (p. 43). I therefore decided to follow the example of these leaders and not offer translations. All kupu Māori used in this thesis are readily available through Te Aka (Moorfield, 2005) which is available in print, for free online or for a small fee as an app on your phone. Te Aka incorporates a speaker function, that allows learners to hear the correct pronunciation of words. ChatGPT and search engines such as Google and Bing also offer easily accessible translations, although kaiako of te reo Māori recommend caution with these options.

If there was ever any doubt about the legitimacy of not offering translations as an option in my own writing, it was erased when I read an article by Alice Te Punga about a well-meant recommendation to italicise foreign words (Te Punga Somerville, 2022b). The following poem appeared in the online article and is the opening poem in her book.

Kupu rere kē

My friend was advised to italicise all the foreign words in her poems.
This advice came from a well-meaning woman
with NZ poetry on her business card
and an English accent in her mouth.
I have been thinking about this advice.
The publishing convention of italicising words from other languages
clarifies that some words are imported:
it ensures readers can tell the difference between a foreign language
and the language of home.
I have been thinking about this advice.
Marking the foreign words is also a kindness:
Every potential reader is reassured
that although obviously you're expected to understand the rest of the text,
it's fine to consult a dictionary or native speaker for help with the italics.
I have been thinking about this advice.
Because I am a contrary person, at first I was outraged —
but after a while I could see she had a point:
When the foreign words are camouflaged in plain type
you can forget how they came to be there, out of place, in the first place.
I have been thinking about this advice
and I have decided to follow it.
Now all of my readers will be able to remember
which words truly belong in Aotearoa *and which do not (Te Punga Somerville, 2022a, p. 5).*

Local dialects

At times throughout this thesis and specifically within the findings chapter, different dialects of te reo Māori representing individual iwi are used. These kupu reflect the use of the participant and it would be inappropriate to change these based on my beginner knowledge. An example of this is tūpuna, a commonly used kupu in my own iwi, Ngāpuhi. In Eastern areas of Aotearoa however tīpuna is preferred.

Definitions

This section provides definitions of some terms that are key in this research to ensure a common understanding.

Crown health organisation

The use of the phrase "Crown health organisations" in the research question is intended to encompass government funded public health providers in Aotearoa during a time of change. Over

the course of this research District Health Boards (DHBs) have been disestablished as a part of national health reforms in an attempt to simplify a complex health system (Department of the Prime Minister and Cabinet, 2022). Relevant for this research is a promised improvement in hospital and specialist services in the future, by planning and managing them through wider regional networks (Department of the Prime Minister and Cabinet, 2021). Te Whatu Ora Health New Zealand and Te Aka Whai Ora Māori Health Authority were established under legislation in July 2022 (Pae Ora (Healthy Futures) Act, 2022), and less than two years later Te Aka Whai Ora is due to be disestablished on 1 July 2024 (Pae Ora (Disestablishment of Māori Health Authority) Amendment Act 2024).

The use of the phrase Crown health organisations rather than DHB, Te Whatu Ora or Health New Zealand was initially in response to these health system changes, reflecting the need to describe the institution that Māori clinical leaders are working in, regardless of its name. Kaupapa Māori research methodologies challenge the dominant Western narrative/s and associated power dynamics, ensuring Māori are not articulated as "other" (Pihama, 2017). Crown health organisations incorporate predominantly Tauiwi provider services including inpatient, community based and outpatient public hospital services, which are often referred to as "mainstream". The reference to Crown health organisations throughout this research is a resistance of the temptation to use "mainstream" to describe services that are not designed and delivered by Māori, for Māori. At the time of writing this thesis, this choice also reflects the fact that even substantial, national structural change has not resulted in change to the systemic racism rife in these institutions or delivered on improvement in inequities in health for Māori.

In 2021, there were 68 public hospitals in Aotearoa, excluding mental health providers (Ministry of Health, 2021). Public hospitals in Aotearoa provide publicly funded health and disability services through inpatient, outpatient and day case care, covering medical, surgical, maternity, diagnostic and emergency services (Ministry of Health, 2021). These Crown health funded hospitals, and their services represent a substantial area of healthcare provision in Aotearoa, and therefore are worth research attention.

Clinical leadership

Māori perspectives of leadership are explored in detail within the literature review and therefore are not defined thoroughly here. This research however specifically refers to Māori *clinical* leadership, referencing a link back to clinical practice, or interaction with patients. Stanley and Stanley (2018) completed a literature review to explore what the term clinical leadership means, concluding that "clinical leaders are recognised for having their values and beliefs parallel their actions and

interventions" (p. 1742). Clinical leaders are not necessarily identified by a job title, however they are central to the provision of care and influence those around them to continually improve the care they provide (Stanley & Stanley, 2018). An example of clinical leadership witnessed in practice in the forming of this research, was a Māori allied health assistant who was observed providing expert knowledge to a paediatric team on the clinical application of tikanga to improve experiences for tamariki and their whānau, in addition to her health assistant job description. Braithwaite et al. (2017) identified that while it is senior policy and managerial stakeholders who have responsibilities to set the organisational agenda, real change requires the involvement of those leaders at the coal face. They suggested specifically that change in public hospitals needs to have a bottom-up approach factored in. Māori clinical leaders have been identified in this research as potential changemakers able to make change from the ground up.

Thriving

Thriving has been chosen as a term in this research question because of the imagery that the word provides. The image of a Māori clinical leader thriving suggests someone who is happy and confident, working in an environment where they are valued and connected with others. A thriving clinical leader has opportunities to learn and grow in a safe space and has a sense of achievement. There are studies devoted to thriving at work in healthcare, primarily focused on nursing workforce (Lyman et al., 2023; Zhai et al., 2023). In Aotearoa, Tofi (2022) looked at what Māori and Pacific allied health practitioners need to be able to thrive in their first years of practice, finding that opportunities for cultural development, valuing cultural intelligence and culturally safe and enriching environments are key ingredients. Spreitzer et al. (2005) proposed a definition of thriving at work as 'the psychological state in which individuals experience both a sense of vitality and a sense of learning at work' (p. 538) that has subsequently been used throughout literature on thriving. Their indication that both vitality and learning are indispensable to thriving at work resonates, however this work subsequently talks about individuals 'stagnating' if they lack opportunities to learn. While this is undoubtably true for some groups, there is no literature that identifies stagnating as a risk for Indigenous workforces. I suspect this is due to the more immediate concerns of colonisation, racism and cultural loading. Sprietzer et al. (2005) also suggest that individuals who thrive have self-awareness and insight into their own potential. Zhai et al. (2023) link personal thriving with thriving as a collective, which has synergies with Māori values such as kotahitanga. From a te ao Māori perspective it is not unreasonable to suggest that Māori clinical leaders can see the potential not just within themselves, but for Māori thriving as a whole. The right leadership is important for enabling and advocating for teams to thrive (Tofi, 2022; Zhai et al., 2023). Research into thriving at work has identified its importance for several reasons, including increasing amounts of time spent at work,

fostering resilience and cost savings for organisation by reducing absenteeism (Zhai et al., 2023). The Health Workforce Plan 2023/2024 identified developing “support for kaimahi Māori to thrive in the workplace” as a key action in order to retain and grow this workforce. This development included support into leadership roles but did not describe how (Te Whatu Ora - Health New Zealand, 2023). For this research, the focus on thriving is centred on the knowledge that we need more Māori clinical leaders in Crown health organisations and that a leader who is thriving can support others to thrive.

Tauiwi and Pākehā

The terms Tauiwi and Pākehā are both used throughout this research. Tauiwi is defined as a person coming from afar (Moorfield, 2005). It can be seen in recent literature about decolonisation and anti-racism to reflect a broader representation of the range of non-Māori ethnicities represented in the healthcare sector (Kidd et al., 2020). Pākehā is often used where a direct description of European settlers or New Zealander of European descent is more appropriate (Moorfield, 2005).

Decolonisation

Colonisation and the impacts of colonisation on the health of Māori are described in detail in the following section to provide context. Also foundational to this research is the concept of *de*colonisation. Decolonisation is a process of developing critical consciousness and re-centering the worldviews of the colonised and can be applied to many different environments, including education, healthcare and research (Chilisa, 2020; McGuire-Adams & Giles, 2018; Reid et al., 2019; Smith, 2012). Smith (2012) described the decolonisation of research as enabled through kaupapa Māori approaches. By privileging mātauranga Māori in research, Māori beliefs are normalised rather than viewed through a western lens (Moewaka Barnes & McCreanor, 2019; Smith, 2012). Pihama (2011) described interrupting colonisation through questioning, reflecting and challenging fundamentals derived from colonial understandings. This research will support decolonisation using kaupapa Māori methodology, centering Māori worldviews and enacting values and tikanga throughout the research process. An important aspect of decolonisation in health research is re-framing a deficit perspective. This is described further below, where colonisation and deficit framing are part of the overall health context for Māori and Māori clinical leaders.

There have been several purposeful decisions in the creation of this research and in writing this thesis to support decolonisation. These will be explored as the thesis progresses and include privileging of te reo Māori (introduced above), choice of data analysis framework and ongoing points of reflection on the impact of colonisation for myself as a novice kaupapa Māori researcher.

The Historical and Contemporary Landscapes

There is growing awareness of the positive impact of Māori leadership in the current healthcare landscape, although acknowledgement of the importance of Māori leadership is not new. Durie (1998) clearly connected improvements in Māori health over the last century to strong Māori leadership. It is widely understood in literature and policy that Māori leadership is an important determinant of improvement in Māori health (Came, McCreanor, Haenga-Collins, & Cornes, 2019; Durie, 1998; McClintock et al., 2014; Munro, 2016; Tipene, 2017; Waitangi Tribunal, 2019). In an annual report to the Minister of Health in January 2022, it was highlighted how critical Māori leadership is and that under-representation of Māori in the current workforce exacerbates the invisibility of Māori in leadership positions, inhibits role modelling for Māori and results in cultural loading on just a few (Health Workforce Advisory Board, 2022).

In the same way that whakapapa in kaupapa Māori research allows us to examine layers of connection in our history to understand and describe where we are now (Smith, 2012), historical contexts can aid in understanding current contexts. This section explores historical contexts that have led to contemporary healthcare environments. I utilise recent literature to understand the experiences of Māori in hospitals in Aotearoa, including the experiences of kaimahi Māori, to illuminate the need for Māori leadership in health.

Te Tiriti o Waitangi and health

In 1840, Te Tiriti o Waitangi (Māori text) and The Treaty of Waitangi (English text, the Treaty) were signed by the British Crown and Māori. Te Tiriti o Waitangi is widely accepted to be a constitutional document that guides the relationship between the Crown in New Zealand (embodied by our government) and Māori (Ministry of Justice, 2020). There are fundamental differences between the English and the Māori texts (Orange, 2015). The Treaty recognised a partnership relationship between Māori and the Crown, while Te Tiriti o Waitangi promised Māori Tino Rangatiratanga (self-determination) and kāwanatanga (decision making/government) (Ruru & Kohu-Morris, 2020). Māori were also promised equal access to the benefits of British citizenship, including access to healthcare (Cram et al., 2019). Importantly, in international law the principle of contra proferentem applies where there is ambiguity. This means that the Indigenous text, in this case Te Tiriti o Waitangi, takes preference (Healy et al., 2012). New Zealand has an obligation to observe Te Tiriti o Waitangi through the International Covenant on Civil and Political Rights, an international law to protect the rights of minorities (Ministry of Justice, 2020) and the Universal Declaration of Human Rights (United Nations, n.d.). A breach of these rights, and the basic right to health are the causes of Indigenous health inequities (Jones et al., 2019).

From the time when Te Tiriti o Waitangi was signed, Māori have been lobbying the Government to honour the Treaty contract (Harris, 2004; Hudson & Russell, 2009). The Treaty of Waitangi Act was passed in 1975, solidifying the importance of the Treaty to New Zealand. This Act enabled the establishment of the Waitangi Tribunal which first convened in 1977 (Durie, 2012). The tribunal influences resolution efforts between Māori and the Crown, making recommendations on claims of inconsistencies in the application of the principles of the Treaty (Hayward & Wheen, 2016; Ministry of Justice, 2020). These principles were developed by the Royal Commission on Social Policy who affirmed that these were relevant to health and social policy (Durie, 2012). In past years there was a suggestion that Te Tiriti o Waitangi was difficult to enact because of the differences between the two versions (Kingi, 2006; Network Waitangi Ōtautahi, 2020). Rather than referencing one or the other, the Crown referred to "principles" as a way of ensuring that the general premise of Te Tiriti o Waitangi was enacted, creating a common language (Gover & Hancock, 2001). In the health sector, these principles have been referred to as the 'three Ps', partnership, participation and protection (Waitangi Tribunal, 2019). They are now understood to be reductionist, and a "watering down" of what should be Crown commitments (Te Karu, 2021, p. 96; Waitangi Tribunal, 2019). Revised principles have been suggested by the Waitangi Tribunal and are reviewed on page 28.

Colonisation

Colonisation in Aotearoa is the wide-reaching assimilation of Māori into European ways of living, where power and resources are transferred from Indigenous peoples to those arriving from Europe. Colonisation began before the signing of the Te Tiriti o Waitangi in 1840 and has continued under the assumption of Pākehā cultural superiority (Houkamau et al., 2017; Te Karu, 2021; Walker, 1990). In explaining how colonisation has impacted the creation of health care institutions, Reid and Robson (2007) describe a process whereby new systems are promoted as providing equal opportunities at a time when culture and identity are gradually being lost. They point out that "unless we recognise colonisation as a deliberate and continuous process it is easy to assume that colonising events are accidental, inevitable and over. We must never assume that colonisation is something confined to our past" (Reid & Robson, 2007, p. 4). As a result of colonisation, publicly funded healthcare in New Zealand is western-centric, bio-medical and designed primarily to serve the needs of the majority (Came, McCreanor, Manson, & Nuku, 2019; Graham & Masters-Awatere, 2020).

Racism

Racism is a determinant of health and goes hand in hand with colonisation (Harris et al., 2019; Houkamau et al., 2017; Jones et al., 2019; Ministry of Health, 2020a; Te Karu, 2021). The Ministry of Health has acknowledged institutional racism in New Zealand's healthcare system as a pattern of

differential access to material resources, cultural capital, social legitimation and political power that disadvantages one group while advantaging another (Garner, 2010; Ministry of Health, 2020a). This is reinforced by policies that have been informed by colonisation (Came, McCreanor, Manson, & Nuku, 2019). When unequal outcomes from these systems and policies that are created to suit the majority are obvious, such as those in health, the problem is often said to lie with Indigenous communities (Reid, 2021; Reid & Robson, 2007). Discourse such as that happening in New Zealand whereby Māori are blamed for ill-health due to non-compliance or poor health behaviour is an example of deficit framing (Waitangi Tribunal, 2019). Historical practices of colonisation enacted by the Crown, assumptions of cultural superiority and deficit framing are all examples of racism (Came, McCreanor, Manson, & Nuku, 2019; Harris et al., 2019; Smith, 2012).

Waitangi Tribunal Health Services and Outcomes Inquiry

In response to years of continued inequity for Māori, the Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575) was initiated in November 2016 and will hear all claims regarding grievances relating to health services and outcomes (Ministry of Health, 2020a). By June 2020 there were 220 historical and contemporary claims covering a range of issues. The Waitangi Tribunal released its Report on Stage One of Wai 2575 inquiry in 2019 (the Hauora Report). The first stage addressed primary health, established under the New Zealand Public Health and Disability Act 2000. It is primarily funded and overseen by the Ministry of Health and district health boards, which are responsible for the system and its performance (Waitangi Tribunal, 2019). The Waitangi Tribunal acknowledged and highlighted issues with a system designed to suit the majority:

> *"A 'one-size fits all' model tends in practice to suit the needs of the majority, who are rarely the group in most need of help. Even when they can access mainstream aid and services, minority groups such as Māori have often found that what is being provided simply does not work for them or is so alienating that they prefer to disengage" (Waitangi Tribunal, pp. 3776-3777).*

One of the key findings of the Hauora Report included the recommendation that the Crown acknowledge the overall failure of legislative and policy framework of the New Zealand primary health care system to improve Māori health outcomes (Waitangi Tribunal, 2019). Other recommendations included revision and expansion of the principles of Te Tiriti o Waitangi touched on above. These expanded principles have been adopted by the Ministry of Health as a framework for meeting obligations in day to day work (Ministry of Health, 2020b). These expanded principles are tino rangatiratanga, equity, active protection, options and partnership (Waitangi Tribunal, 2019). Tino rangatiratanga as a principle for the Ministry of Health encompasses self-determination in all

aspects of health and disability services including design and delivery of services. The principle of equity is defined as commitment to achieving equitable outcomes, while active protection ensures that the Crown acts in the fullest extent to achieve those equitable outcomes. The principle of options describes an obligation of the Crown to resource kaupapa Māori health services appropriately and ensure all health and disability services are provided in a culturally safe way. Partnership involves the Ministry of Health working with Māori in all aspects of health and disability services (Ministry of Health, 2020b).

Māori Experience in Healthcare

In the public health system in New Zealand, including hospitals, Māori patients typically receive inequitable access to interventions and quality of care, consistently report negative hospital experiences and are often discharged earlier than Pākehā patients (Graham & Masters-Awatere, 2020; Wilson & Barton, 2012). Wilson and Barton (2012) completed case studies with 11 Māori patients who had accessed hospital care for medical or surgical interventions. They combined this with a systematic literature review of Indigenous experiences in hospital systems. Their findings were unsurprising and confirmed that Indigenous peoples are marginalised within Crown health systems, that hospital environments are not conducive to Indigenous health and that negative experiences contribute to early discharge.

In a qualitative meta synthesis, Graham and Masters-Awatere (2020) aimed to answer the research question "What are the experiences of Māori in the public health and/or hospital system in Aotearoa New Zealand?" (Graham & Masters-Awatere, 2020, p. 193). Through their review of 14 qualitative papers published over 20 years from 2000 to 2020 they explored perspectives of Māori patients and their whānau of their treatment in the public health system. Their review found both barriers and facilitators to health. Barriers included: organisational structures such as devaluing cultural practices; staff interactions including inappropriate information provision; and practical considerations such as travel times to access urban facilities. Facilitators of access to public health for Māori included: the provision of whānau support in the form of practical assistance; emotional care such as providing compassion; and assistance with navigation through the health system. In a distressing conclusion, these authors determined that many Māori find the public health system and hospitals hostile and alienating. These experiences have the potential to not only impact on the patient immediately accessing public healthcare, but also on their whānau observing this experience. Negative experiences can result in a lack of trust in the both the health system and those working within it (Komene et al., 2023; Wilson, Barton, & Tipa, 2022).

Hunter (2019) highlighted that it is not always Māori accessing healthcare who feel alienated, but that Māori nurses working within publicly funded healthcare can feel like foreigners themselves. Komene et al. (2023) confirmed this in their research on the experiences of Māori nurses in acute hospital services. They determined that it was not unusual for Māori nurses working to feel routinely compromised as they devalue their own wellbeing to address systemic inequities in their work and resolve conflict between biomedical models of health and Māori models of wellbeing. Komene et al. (2023) also reinforced the value of the Māori nursing workforce. Māori want to be treated by Māori, and Māori nurses are able to bring their understanding of te ao Māori to meet the needs of Māori patients and their whānau (Komene et al., 2023).

There is a growing body of evidence on the subject of Māori leadership in Crown health organisations, which will be explored in detail in the literature review chapter. However, there is a chasm between what is strategised for improving Māori health and what happens in practice at the coal face (Hunter, 2019). Following on from the reports that exposed comprehensive, consistent, and compelling health inequities for Māori (Health and Disability System Review, 2020; Waitangi Tribunal, 2019), Reid (2021) argued that the implementation of upcoming health reform plans required strong Māori voices and advocacy as opposed to silence and inaction to change the culture in health systems. In her editorial Dovey (2021) suggested that an emerging generation of "articulate bicultural New Zealanders" (p. 93) who will be responsible for lasting changes in New Zealand's health system. Māori leadership in health is an important component of improving health outcomes, and is required at all levels of the public health system (Ministry of Health, 2020b).

Curtis et al. (2022) identified a number of issues for Māori operating within Crown health structures and reporting to non-Māori management and leadership. The authors noted that the autonomy of Māori to govern as Māori has been limited and that Māori initiatives have been subjected to a high degree of scrutiny and evaluation. They identified that Māori governance is tokenistic, with endorsement sought after policies and programmes have been designed despite the availability of Māori technical and content experts (Curtis et al., 2022). This observation of imbalance of power is supported by Came (2014) through her discussions of democracy and her assessment that democracy is useful only for dominant groups. In further work Came et al. (2021) noted that in order for Māori to govern effectively mechanisms need to be put in place to distribute power and enable Māori to make decisions for Māori.

Participants in a study by Came, McCreanor, Haenga-Collins and Cornes (2019) expressed concern at the lack of effective Māori leadership in policy making and through the health sector. Participants in

research by Kidd et al. (2020) on nurses perspectives of anti-racism praxis identified the importance of Māori leadership in expanding the Māori nursing workforce.

Māori leadership is referenced in national health policy and strategy, including Te Pae Tata Interim Health Plan (Te Aka Whai Ora - Māori Health Authority & Te Whatu Ora - Health New Zealand, 2022) and the Interim Government Policy Statement (iGPS) (Ministry of Health, 2022). Whakamaua: Māori Health Action Plan (Whakamaua) was published in 2020 (Ministry of Health, 2020b), and is the implementation plan for He Korowai Oranga the Māori health strategy (Ministry of Health, 2014). It lists priorities for action to continue improving Māori health through until 2025. The second of the key priorities listed is Māori leadership. This priority acknowledges the significance of Māori leadership in enabling Māori health equity and wellbeing (Ministry of Health, 2020b). A quote from a He Korowai Oranga stakeholder is included:

> *"We need Māori at all levels of decision-making. Māori leadership is not just confined to the board level; it must be throughout the health system, including executive management and team leader levels as well as clinical directorships and clinical leaders" (Ministry of Health, 2020b, p. 39).*

Pae Tū: Hauora Māori strategy (Pae Tū) draws from Whakamaua and identified Māori leadership as a focus area that is linked to all of the strategies outcomes (Minister of Health, 2023). It identified clearly that Māori leadership is central to Māori health advancement across the health system and that the health system must encourage and grow diverse Māori leadership. A quote from a stakeholder wānanga recommended that future leaders should be nurtured "to sit around the tēpu to be actively involved and included" (Minister of Health, 2023, p. 31).

Kupu Whakatepe

In this background chapter I described who I am and my whakapapa and positioned myself within the research context. I have also positioned the use of te reo Māori, establishing the privilege that this deserves within my research and introduced some initial terminology. In this chapter I have provided contextual background information that defines and establishes both the setting that Māori clinical leaders work within and the reasons why Māori clinical leadership is important. I have briefly touched on Te Tiriti o Waitangi and made links between Te Tiriti o Waitangi and health and introduced colonisation. Racism was established as a current issue facing Māori who access and work in the healthcare system in Aotearoa. I have established that this research will support decolonisation by illuminating Māori leadership practices and challenging dominant western views of leadership in Crown health organisations.

The following chapter will provide a systematic review of literature specifically related to Māori leadership in Crown health organisations. It identifies current research and knowledge, identifying areas that are under researched and require strengthening.

LITERATURE REVIEW

This chapter presents a detailed literature review which explores Māori leadership in health. The aims were to investigate what is currently known about Māori leadership in health and what Māori leaders' experiences in crown health organisations in Aotearoa have been. These queries, approached in a systematic way further establish the context for this research and identify gaps in knowledge.

Method

A systematic search and review style was chosen, as the approach is capable of addressing broad questions, and can include multiple different study designs (Grant & Booth, 2009). It requires a systematic search strategy, and the resulting literature is reviewed in an informal way that does not require the use of a standardised tool (Grant & Booth, 2009).

This review utilised the SCOPUS, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Medline via EBSCO, Pubmed, and Business Source Complete databases to search for literature. These databases were complemented by searches of NZResearch.org for relevant theses. Search terms used were māori or maori or maaori, leader or leaders or leading or leadership, and hospital or health or DHB or district health board or management. Each database search started broadly with Māori and alternatives and leadership (and alternatives) before delving specifically into the context of health. Search terms initially included clinical and variations, however this returned no additional results. Additional searches were undertaken with kupu Māori that reflect leadership, including rangatira, rangatiratanga, manukura and kaitiaki. Manual searches were also undertaken of article reference lists.

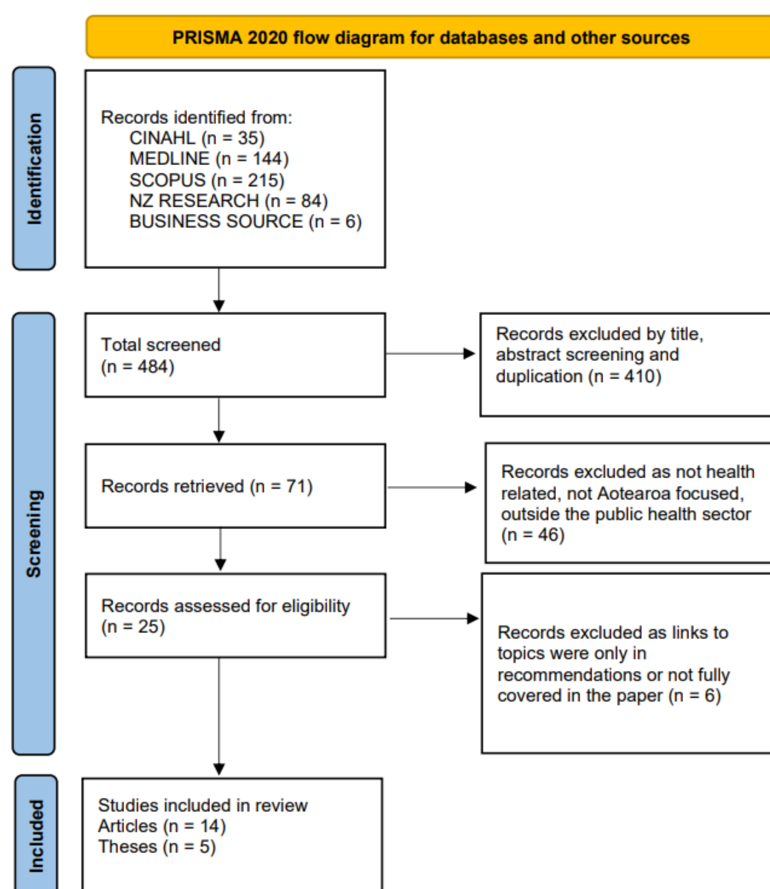
Table 1: Literature review inclusion and exclusion criteria

<table>
<tr><th>Inclusion</th><th>Exclusion</th></tr>
<tr><td>Geographic: Aotearoa New Zealand</td><td>Geographic: International</td></tr>
<tr><td>Subject: Māori leadership</td><td rowspan="2">Setting: Private healthcare, General Practice, Non-government organisations, education settings/academic leadership, business, sport</td></tr>
<tr><td>Setting: Publicly funded (Crown) health settings (hospitals, community services, public health services, health promotion)</td></tr>
<tr><td>Dates: All dates included</td><td rowspan="3">Grey literature: social media, news reports, board meeting agenda and minutes, reports</td></tr>
<tr><td>Study type: peer-reviewed, qualitative and quantitative</td></tr>
<tr><td>Grey literature: theses</td></tr>
</table>

Results

The online database search by abstract with the search terms listed above resulted in 484 titles. A significant majority were excluded immediately by title as irrelevant before application of exclusion and inclusion criteria. All remaining papers (71) were screened by title, subject and keywords against exclusion and inclusion criteria presented in Table 1. Within the 71, although leadership was not the key focus of some research, these results emerged as Māori leadership was frequently recommended in response to an issue or Māori leaders were consulted on an issue which was therefore represented in the abstract or keywords. For example cardiovascular health improvements for Indigenous women (McBride et al., 2021) and Iwi-led response to the COVID19 pandemic (Russell et al., 2023).

Figure 1: Modified PRISMA flow diagram to illustrate literature search



Adapted from "The PRISMA 2020 statement: An updated guideline for reporting systematic reviews," by Page et al. (2021), *PLoS Med* 18(3): https://doi.org/10.1371/journal.pmed.1003583

Figure 1 represents the narrowing of papers for inclusion. A total of 14 peer reviewed articles and 5 theses were reviewed and are presented in a table in appendix A. Grey material such as editorials, newspaper and social media were excluded. Ministry of Health documents and Waitangi Tribunal reports were also excluded, as these have been thoroughly discussed in the background chapter to inform professional and system wide discussion.

Nvivo software was used to manage information by storing included articles. Key ideas from each article were highlighted in Nvivo, then grouped into potential themes with ongoing condensing and analysis for refinement until three key themes remained. Themes identified throughout readings were: Māori values expressed in leadership; Māori leadership to provoke change; and advancing Māori leadership. These are explored in detail below to articulate the current knowledge of Māori leadership in health in Aotearoa.

Māori values expressed in leadership

The first theme captures the importance of Māori values for Māori leaders in health. The expression of values and the importance of leaders who can maintain these in their leadership were clearly described across several studies. Adherence to and knowledge of tikanga is a vital aspect of Māori leadership (Forsha, 2017; Haar et al., 2019; McClintock et al., 2014; Tipene, 2017; Wakefield, 2023), and is the key to how Māori demonstrate values day to day (Moko Mead, 2016). Tikanga Māori is a system of values and practices that have developed over time and focuses on the correct or tika way of doing something, including “moral judgements about appropriate ways of behaving and acting in everyday life” (Moko Mead, 2016, p. 7). Wikitera (2011) proposes that while it is important for Māori leaders to understand tikanga, it also important to convey aspects of tikanga into daily leadership routine. She indicates that operationalising tikanga into an organisation is challenging as it is often not seen as practical. Winiata (2012) discussed a leader’s ability to motivate through use of tikanga while Panesar et al. (2021) highlighted that the reciprocal relationships between leaders and team members are informed by tikanga.

Haar et al. (2019) recognised the importance of positive leadership within organisations and emphasised Māori leadership as an example of this. They completed a series of three studies aiming to confirm the role of Māori values and ethical leadership from the perspectives of both Māori leaders and employees. Values that arose from interviews with nominated Māori leaders were whakaiti (humility), ko tau rourou and manaakitanga (altruism), tāria te wā and kaitiakitanga (time orientation & sustainability), whanaungatanga (relational orientation) and tikanga Māori (Haar et al., 2019). Importantly, Haar et al. (2019) noted following their outline of Māori values that it is impossible to translate a Māori value with all its history and variety of applications into one English

word. Instead, they referred to the translations above as touchpoints, or areas of commonality. Wikitera (2011) described similar values of reciprocity, building relationships, leading through serving people and mutual understandings. Forsha (2017) explored leadership through the lens of Māori, identifying the values of manaakitanga (nurturing others) and whanaungatanga (connection and relationship) as cornerstones of Māori leadership.

In her thesis, Tipene (2017) explored the meaning of Māori leadership in public health for the public health practitioners and compared this to a western view of leadership. She interviewed 11 Māori practitioners and was able to conclude that Māori values are predominately what guides Māori public health leaders. She discussed how pivotal values are in te ao Māori in comparison to te ao Pākehā where health has a medical and individualistic view and identified further research opportunities investigating how to elevate the importance of Māori leadership values in public health. In addition to identifying Māori values as essential for Māori leadership, the nursing leader participants in a study by Wakefield (2023) also identified being able to enact values as essential for personal wellbeing. This particularly included whānau and whanaungatanga in relation to opportunities to form connections.

Although not a value per se, the concept of mana is identified in literature as a crucial component underpinning Māori leadership (Forsha, 2017; Tipene, 2017; Winiata, 2012). Winiata (2012) explored Māori nurse leadership practice in a whānau ora context. She recognised that people with mana tend to be in leadership roles and goes as far as identifying mana as a Māori leadership style. She acknowledged that individuals are born with mana, but also that a strong leader in turn enhances their mana through helping Māori to prosper. Leaders with mana are seen as having the skills, charisma and ability to inspire followers and influence change (Katene, 2010; Tipene, 2017; Winiata, 2012). None of the studies discussing mana of leaders identified the positional title as a determiner of mana, with participants of the study by Tipene (2017) identifying that being a leader was more about being action focused and working at the coal face as needed.

Māori Leaders Navigating Te Ao Pākehā

It is well recognised in literature on Māori leadership both in general and specifically in health that the values of western centric health and Māori centric health are different, and as a result Māori leaders must balance the two worldviews of Māori and Pākehā (Haar et al., 2019; Katene, 2010; McClintock et al., 2014; Tipene, 2017; Wikitera, 2011). The interaction of leaders between te ao Māori and te ao Pākehā are described in subtly different ways in the literature, varying between a balancing act, the use of values in one world to impact another and caution around too much compromise. McClintock et al. (2014) described effective leadership as the interface between

Indigenous and mainstream worldviews while Haar et al. (2019) proposed that Māori draw on traditional values to assist decision-making while navigating western organisation perspectives. Other authors noted that Māori were often required to balance their cultural values and the expectations of the Crown health services they work in, constantly making adjustments (Tipene, 2017; Wakefield, 2023; Wikitera, 2011). Katene (2010) and Wakefield (2023) both emphasised how important it is that Māori values and therefore the integrity of leaders are not compromised as leaders negotiate their way through te ao Pākehā based organisations. In Crown health organisations this balance of cultures requires using Pākehā medical and clinical perspectives where traditional Māori treatment may not be welcomed (Tipene, 2017). Māori leaders have described needing to battle to have their voices heard in Pākehā spaces such as boardrooms and using a range of skills such as whanaungatanga to highlight their professional qualifications and add western status to their Māori perspectives (Came, McCreanor, Haenga-Collins, & Cornes, 2019). They were required to be well versed in both te ao Māori and te ao Pākehā, being accountable to employers, feeling accountable to iwi/communities and being strategic in their actions to get Māori viewpoints across (Tipene, 2017). Sadly although unsurprisingly, Māori nurse leaders identified that the navigation between te ao Māori and te ao Pākehā worldviews such as the incorporation of tikanga into clinical practice, is challenging and a source of tension for them (Wakefield, 2023).

Māori leadership of change

Many references to Māori leadership in healthcare are related to establishing change and effecting health improvements (Came, McCreanor, Haenga-Collins, & Cornes, 2019; Durie, 1998; Gifford et al., 2010; Katene, 2010; McClintock et al., 2014; Severinsen et al., 2021). The need for Māori leaders to be outspoken and to be able to advocate for Māori is frequently mentioned (McClintock et al., 2014; Sampson, 2019).

Sampson (2019) looked at the experience of Māori doctors and what it means to be a Māori doctor and identified that taking up leadership roles was a key concept for his participants. These roles included serving on boards, teaching, being expert clinicians and leading improvement programmes (Sampson, 2019). Those interviewed identified whakatoatoa as a key attribute for Māori doctors, linking this with a need to provide a Māori voice to influence changes and ultimately improve Māori health (Sampson, 2019). Severinsen et al. (2021) provided a clear example of Māori leadership speaking out to facilitate change for Māori health. They looked at examples of Māori leadership in response to the ongoing COVID-19 pandemic. In addition to the set-up of road checkpoints around vulnerable rural communities, Māori leadership was also seen in the form of sustained campaigning which led to changes of rules surrounding tangihanga during the pandemic.

Māori nursing leaders have been identified as being at the forefront of constitutional change in Aotearoa, providing evidence for the Waitangi Tribunal and taking on activism roles (Brockie et al., 2023). In a kaupapa Māori case study approach, Brockie et al. (2023) looked at Indigenous nursing leadership in Canada, Australia, USA and Aotearoa. They concluded that the strong leadership provided by Indigenous nurses influences outcomes and that Indigenous leaders are well placed to transform wellbeing services and health systems.

Māori representation in governance or as advisors of boards is also linked to positive effect on health improvements for Māori. Came, McCreanor, Haenga-Collins and Cornes (2019) explored the experiences of six Māori and Pacific leaders on health policy advisory committees. They chose health leaders based on years of experience, and experience representing Māori and Pasifika people in numerous Ministry of Health, District Health Board advisory or steering groups. Each of these participants was interviewed about their experiences, and themes were identified from collated results. Themes identified were navigating the room: the battle of evidence; working with government officials; suspicions of tokenism and witnessing and experiencing racism. All leaders involved reported variable success influencing health policy and advised that to be effective and to be heard in such groups required participants to be forthright, resourceful and tenacious. Came, McCreanor, Haenga-Collins and Cornes (2019) concluded that more could be done, such as accurately recording input to ensure Māori and Pasifika leaders are respected so that they can fully engage in advisory groups.

In an article examining leadership theories from a Māori perspective, Katene (2010) notes the importance of transformational leadership, a leadership style that is found to be beneficial to lead organisational and cultural change. Transformational leaders can inspire their followers into achieving more than they thought possible (Katene, 2010). McClintock et al. (2014) also recognise Māori as transformative leaders. They reviewed the history and contribution of the Henry Rongomau Bennett (HRB) Foundation in Māori leadership development, noting that health advancements for Māori are linked to Māori culture and cultural realities. Challenging systems to improve outcomes for Māori requires Māori leaders to have the confidence to raise the profile of Māori world views of leadership in the conventional health system (McClintock et al., 2014; Sampson, 2019; Tipene, 2017). Wiapo and Clark (2022) examined leadership theories and identified attributes displayed by Māori leaders, including an ability to challenge the status quo, bring people together and a willingness for personal growth. These traits echo those identified by Tipene (2017) and Sampson (2019) as important to elicit change for Māori.

The Weight of Expectations

The additional expectations that Māori health practitioners and leaders carry, over and above those of their Pākehā counterparts is referenced in literature on leadership of change (Durie, 1998; Sampson, 2019). Māori leaders have a sense of responsibility to improve the health outcomes of Māori communities and effect change as described above (Tipene, 2017). They see themselves as being accountable to Māori by virtue of their ethnicity and culture, experiencing a personal cultural tension and professional conflict which Pākehā leaders do not (Tipene, 2017). Panesar et al. (2021) suggested that the weight of expectation of health improvement does not sit with individual leaders, but that Māori as a whole are assigned the responsibility for Indigenous health in Aotearoa. The burden of responsibility on Māori is linked to a sense of isolation, experiences of being the only Māori person around the table and the feeling of representing an entire disadvantaged majority (Came, McCreanor, Haenga-Collins, & Cornes, 2019; Panoho, 2012). For example, Panoho (2012) researched Māori representation on District Health Boards and found that Māori were burdened by attempting to address disparate health needs whilst in an isolated and marginalised position.

Advancing Māori leadership

Advancements in Māori leadership in health are suggested in literature through specific leadership training programmes, development of supervision and mentorship, distributed leadership, resources sharing and more recently through development of an Indigenous theory of leadership (Baker, 2009; Pipi et al., 2021; Wakefield, 2023; Wiapo & Clark, 2022). Baker (2009) completed studies with the Māori nursing and midwifery workforce and found that progressing leadership required access to mentoring and peer support including supervision. Baker (2009) identified that specialist leadership training would advance leadership skills. Munro (2016) analysed Ministry of Health policies to determine how they supported Māori leadership development. He identified preferential support for mainstream leadership over Māori leadership for the Māori workforce (Munro, 2016).

Pipi et al. (2021) completed a content analysis on four evaluation reports from Ngā Manukura a Apōpō, a kaupapa Māori leadership training for Māori nurses and midwives. The Ngā Manukura a Apōpō programme was established in 2009 and aims to “better position Māori nurses and midwives to improve the quality of health-service delivery” (Pipi et al., 2021, p. 17). The programme offers the only mention of clinical leadership found during this literature review. The authors briefly observed that leadership and practicing nursing or midwifery are not mutually exclusive ideas for Māori. They concluded that kaupapa Māori leadership development contributes to strengthened cultural identity, essential for strong Māori leadership.

Another technique for the advancement of Māori leadership, again identified in nursing specific research, is role modelling (Wakefield, 2023). Leaders who participated in a study investigating Māori nurse leaders' experiences highlighted that role modelling by and teaching from kaumātua positively influenced their abilities both in the workplace and in their everyday lives. Wakefield (2023) went on to discuss those nurse leaders who did not have whānau to act as role models. She suggested that leadership development programmes such as Ngā Manukura a Apōpō could step in to play a significant role in the development of nurse leaders who lacked Māori role models in other areas of their lives.

Leadership networks in New Zealand health organisations are hierarchical in nature with an imbalance of power favouring Pākehā (Panesar et al., 2021). Panesar et al. (2021) suggested the adoption of a distributed leadership model in health, or a system where leadership is shared between Māori and Pākehā. Following an examination of rangatiratanga, servant and ethical leadership they recommended incorporation of ethical and servant leadership styles into health systems. This shift in traditional hierarchies reflects the intentions of Te Tiriti o Waitangi and is required in order to develop safe environments for Māori and improve health inequities (Panesar et al., 2021).

A final description of advancement of Māori leadership is the development of a whakapapa model of nursing leadership (Wiapo & Clark, 2022). These authors deduced that nursing leadership cannot be separated from the mauri of a person, noting that the roles that a person plays throughout their life, the wisdom from these lived experiences and the inherent mana that they bring influences how they negotiate leadership spaces. Wiapo and Clark (2022) utilised relevant aspects of western leadership models and theories with strands of mātauranga to create an Indigenous model of leadership, pictorially represented as a kete. An aspect of this research that is absent in other studies, is the acknowledgement that navigating the challenging experiences of leadership can result in the development of strengths. Their concluding remarks reminded readers of the aspirations of tūpuna for those that follow to live valued lives with self-determination as Māori (Wiapo & Clark, 2022).

Kupu Whakatepe

This systematic search and review aimed to explore what is currently known about Māori clinical leadership in crown health organisations in Aotearoa. Although only one study was found that incorporated Māori clinical leadership (Pipi et al., 2021), this review demonstrates that the advantages of Māori leadership in health are becoming well recognised in literature. Māori leadership in health is portrayed in literature as values based and has been linked with transformative and legislative change, continuing to play a role in driving improvement for Māori

health and wellbeing (Forsha, 2017; Katene, 2010; Pfeifer, 2005; Tipene, 2017). Maintaining Māori cultural values while working for a Crown health organisation, and maintaining Māori views of health in a western health system are important aspects of Māori leadership that present personal and professional challenges to Māori leaders in healthcare (McClintock et al., 2014; Panesar et al., 2021; Tipene, 2017; Wikitera, 2011). This literature review has identified that the experience of Māori leaders in Crown health organisations has received recent research attention, however, evidence remains primarily tied to single professions with several studies specifically focussed on nursing leadership. Bringing the literature in this review together with research under the overarching concept of clinical leadership will strengthen a collective case for investment in the advancement of Māori clinical leadership in Crown health organisations. There are research gaps in the articulation of the full scope of Māori clinical leadership across professional boundaries and in the examination of Māori clinical leadership, both of which this study aims to address.

The following chapter will describe the research design, delving into the complexities of kaupapa Māori as a philosophical base.

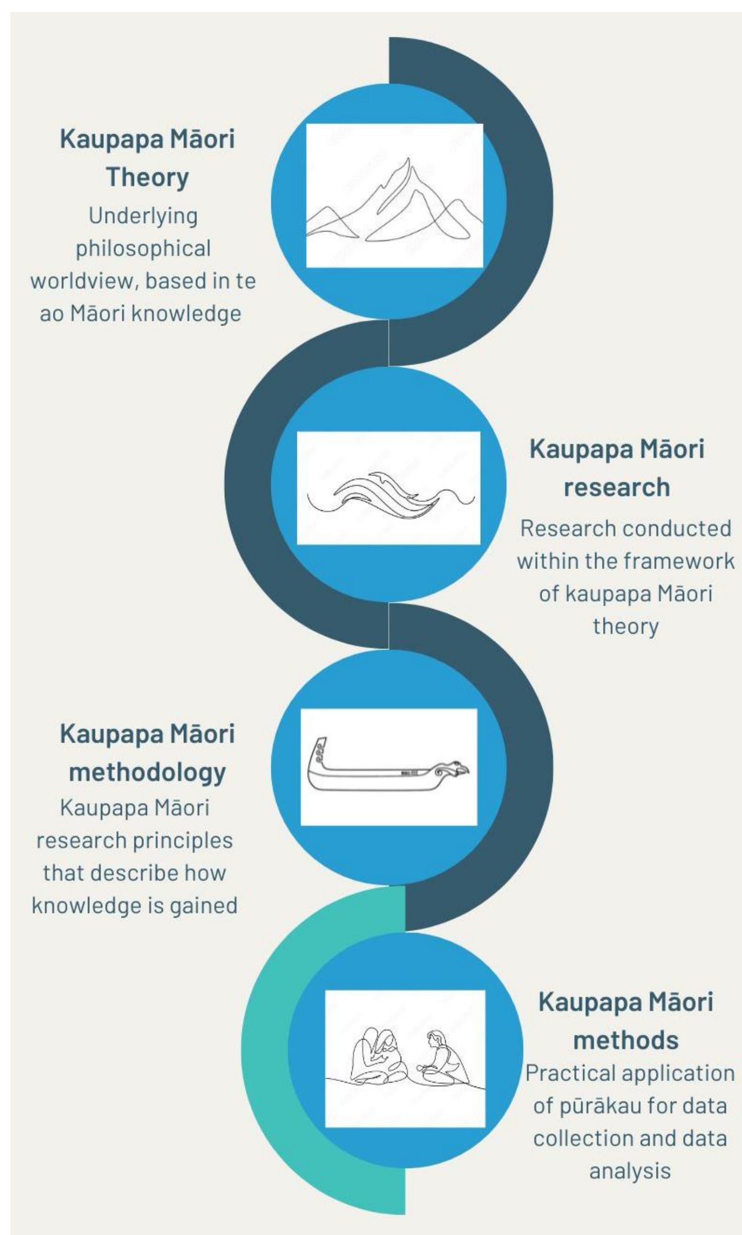
RESEARCH DESIGN

This research design chapter is presented with an overview, the threads of research design, and three key sections. These three sections explore kaupapa Māori, detail how the research was carried out, and describe the approach I used for data analysis. I will review kaupapa Māori research, exploring the influence of critical theory and local critical theory prior to describing the practical application of kaupapa Māori methodology. Finally, I will describe how I analysed the pūrākau of Māori clinical leaders by drawing on reflexive thematic analysis and a pūrākau framework to determine key themes.

The Threads of Research Design

This research design represents multiple threads of knowledge that have been difficult at times to isolate. I have therefore used two illustrations to describe my approach. Figure 2 below provides an overall picture of the research design in its entirety, while figure 3 further in the chapter illustrates the key layers of kaupapa Māori foundational principles, research values and tikanga.

Figure 2: Overall approach to research design



Kaupapa Māori theory represents the philosophical or ontological worldview. It is based in te ao Māori that underpins a Māori way of being, including recognition of interconnectedness between physical and spiritual realms. Kaupapa Māori research makes up the epistemological perspective, it is research conducted within the framework of te ao Māori and underpinned by mātauranga. Kaupapa Māori methodology lays out an understanding of how research practices will be applied and finally kaupapa Māori methods are the practical application of pūrākau and kōrero. In untangling the many facets of kaupapa Māori epistemology from methodology and method, I have found it helpful to keep this simple, clarifying quote from a kaupapa Māori researcher in mind:

> *"Methodology represents the theory of how knowledge is gained and outlines an appropriate approach to systematic inquiry" (Curtis, 2016, p. 398).*

Introducing Kaupapa Māori

Kaupapa Māori is a broad and overarching term, that as an Indigenous philosophy can be applied to a number of areas and disciplines, including health, education and research (Walker et al., 2006). Pihama (2010) described multiple layers of potential meaning, giving kaupapa many possible definitions. Keegan (2012) devoted an entire article to the linguistic history of the phrase kaupapa Māori and noted that it is used freely in contemporary language and it is not always clear which definitions are being referred to. Te Ahukaramū Charles Royal (2007) identified the root of the word kaupapa as papa, also present in Papatūānuku, relating to notions of foundation and base. Marsden (2003) defined the component kau as 'to appear for the first time, to come into view' (p. 66). Kaupapa, therefore, are the principles and strategies that act as a foundation for action (Pihama, 2017; Te Ahukaramū Charles Royal, 2007). Kaupapa Māori is driven by te ao Māori, mātauranga Māori and Māori ways of being that are bigger than a simple application to research (Henry & Pene, 2001; Pihama, 2017). Mātauranga Māori refers to Māori knowledge, which is holistic and encompasses multiple dimensions including language, spirituality, and environmental understanding, while te ao Māori represents the Māori worldview (Cram, 2001; Smith, 2012; Wilson et al., 2021). In his writings, Graham Smith describes kaupapa Māori as a theoretical positioning related to being Māori (Smith, 1997; Smith et al., 2012). Cram (2001, p. 41) outlines these key aspects:

- The validity and legitimacy of Māori is taken for granted,
- The survival and revival of Māori language and culture is imperative,
- The struggle for autonomy over cultural well-being and over their own lives is vital to Māori.

This section introduces the underlying philosophical worldview of kaupapa Māori theory, defining key concepts that support my understanding about the nature of reality from a kaupapa Māori

perspective. The following section reflects assumptions about what constitutes meaningful and valid knowledge, utilising foundational principles outlined by Smith (2012).

Kaupapa Māori Research

This section describes kaupapa Māori research, an epistemological perspective that aims for tino rangatiratanga and to contribute to the decolonisation of research (Smith, 2012). It empowers Māori researchers to view and organise research in alignment with mātauranga Māori as described above (Smith, 2012; Walker et al., 2006). Kaupapa Māori approaches utilised by researchers challenge dominant narratives and accompanying power dynamics (Pihama, 2017). Mahuika (2017) describes its ultimate goal is to privilege Māori perspectives and knowledge.

Smith et al. (2012) reinforced the importance of recognising the roots and history of kaupapa Māori epistemology. Therefore, this section provides a brief description of Marxist critical theory, before delving into its links to kaupapa Māori research and the concept of localised critical theory.

Critical theory refers to one of the range of approaches and perspectives originating from Marxism and social theory (Joseph, 2006). At a basic level, Marxism ideology begins with the notion that the ruling ideas in any society are set by those in power, and human experiences are influenced by the socio-economic and political systems we live in (Tyson, 2011). Critical theory arose in the early 20th century from the Frankfurt school at a time when it was felt that traditional theories were viewed as strengthening established power structures and social inequalities (Joseph, 2006). It begins from a position of assuming that there is already an existing power imbalance in a reality that "is shaped by social, political and cultural events" (Creswell & Creswell Baez, 2021, p. 44). Critical theorists look to uncover underlying dynamics contributing to these power imbalances and subsequent social inequalities, focussing on issues such as class, gender, race, and even religion (Joseph, 2006). The values of the researcher are apparent in the research, and the research itself aims to address power issues that affect oppressed minorities (Creswell & Creswell Baez, 2021). Grant and Giddings (2002) describe critical theory research as a form of conviction research that "is designed not just to explain or understand social reality but to change it" (p. 18).

Smith et al. (2012) described the key underpinnings of kaupapa Māori as being transported out of critical theory, particularly the concepts of critique, resistance, and emancipation. Critical theory is essential to kaupapa Māori research, specifically considering action and emphasising Māori self-development (Pihama, 2017; G. Smith, 2017). In an interview, Pihama (2011) described her realisation that the philosophers behind critical theory wrote for their own political contexts, therefore kaupapa Māori researchers can and should do the same. Kaupapa Māori localised critical theory is a theoretical positioning which acknowledges a historical, political and social context

specific to Māori and Aotearoa (Smith, 1997). It also acknowledges and privileges local theorists, such as Graham Smith, Linda Tuhiwai-Smith and Leonie Pihama among others. Smith (1997) emphasised that critical theory offered an opportunity to oppressed groups such as Māori to take greater control through emancipation. Jackson (2015) explored the association of critical theory with the principle of tino rangatiratanga in the context of the rights of Indigenous people to self-determination. He identified that taking control of the emancipatory goal of critical theory is crucial to self-determination and therefore to health and wellbeing. Taking control through local critical theory prompts us to move away from cultural deficit standpoints of health inequities, where Tauiwi privilege is not examined, because of the belief that deficits are inherent to Māori (Keelan et al., 2022).

Some academics have begun to move away from kaupapa Māori being a critical theory, because of the attention towards colonisation and the negative connotations behind this (Eketone, 2008; Moyle, 2014). Locating my research within critical theory however is appropriate as this research is focused on Māori working within a Crown health organisation, heavily influenced by the socio-political context operating within health systems. Earlier writing within this thesis established that the effects of colonisation are still being felt in the health system, and western perspectives of health in western buildings are the norm, making critique and resistance appropriate. Cram (2001), a supporter of critical theory, emphasises the importance of an approach that facilitates social change in ways that consider the day-to-day realities of the people involved. The dilemma expressed by kaupapa Māori researchers and relevant for this research is ensuring that the critical perspective does not take over, leaving space for acknowledging the strengths of te ao Māori and developing Māori knowledge. This research bridges both, acknowledging the power dynamic at play and seeking mātauranga from the pūrākau of Māori clinical leaders.

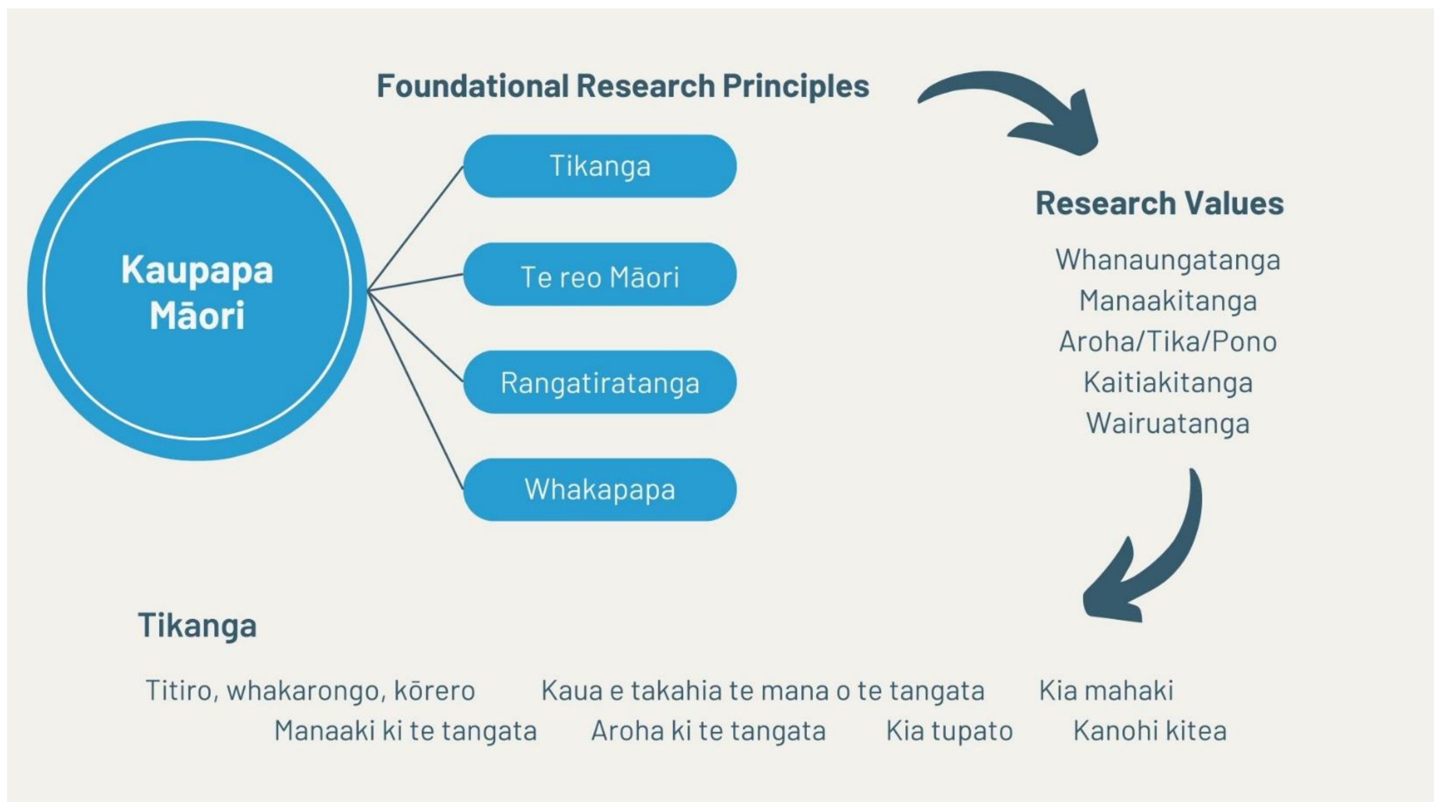
Weaving the threads together

Stevenson (2018) recognised that because of the interdependency between concepts, epistemological foundations are often intertwined with kaupapa Māori research and methods. Examples of this include the use of whanaungatanga to determine whakapapa (Moko Mead, 2016), or relying on tikanga to know how best to demonstrate manaaki and aroha.

In this research, describing the connected and sometimes interdependent concepts that weave between epistemological philosophy, methodological approach and further into the practical application of tikanga presented a challenge. To describe the overall interactions and flow between principles, values, and tikanga of the research, I developed an illustration that supported me to achieve clarity. Figure 3 outlines my thoughts about how the guiding foundational principles of

whakapapa, rangatiratanga, te reo Māori and tikanga (L. T. Smith, 2017) intertwine and influence the values of kaupapa Māori research methodology and the process of research design, data collection and analysis. I have chosen to describe this piece of work as an illustration, as opposed to a framework, because it does not represent the development of new concepts but outlines them in a way that shows how I have applied them to this work. This illustration evolved over the course of the research and following discussion with kaumātua and other members of my research whānau.

Figure 3: Kaupapa Māori principles, values and application of tikanga



Foundational Principles

This section provides insights into the foundational principles in figure 3, which sit at the forefront of the research process. These principles influence all aspects from conception to writeup and underpin the way this research is thought about. These form a strong basis from which the more detailed work can flourish.

The application of principles can differ in research, dependent on the perspectives and contexts of the researcher. Other authors have focused on slightly different depiction of principles or apply these to different points in the research process. For example, others include Te Tiriti o Waitangi as a principle (Moyle, 2014; Pihama, 2001), and the discussion from Smith (2017) about mana wāhine: mana tane as a principle to highlight the complexity present in some Māori social relationships.

Smith and Reid (2000) also refer to six 'intervention elements', articulated by Graham Smith. These include tino rangatiratanga (the 'self-determination' principle), taonga tuku iho (the 'cultural aspirations' principle), ako Māori (the 'culturally preferred pedagogy' principle), kia piki ake i ngā raruraru o te kāinga (the 'socio-economic mediation' principle), whānau (the 'extended family structure' principle), and kaupapa (the 'collective philosophy' principle).

The foundational principles that underpin this research and are depicted in figure 3 above have been described by L. T. Smith (2017); whakapapa, te reo Māori, tikanga and rangatiratanga. Each of these are described below.

Whakapapa

Whakapapa forms the foundations for how knowledge is organised. It is a holistic narrative of identity as it links to both whānau and whenua (Wilson, Mikahere-Hall, & Sherwood, 2022). It recognises layers of connection to and relationships between people, places and historical events (Ngata & Ngata, 2019). It acknowledges broader collective groups, including responsibility to a collective, and how individual people interconnect as part of a wider whole, contrasting directly with a more individualist European worldview (Wilson, Mikahere-Hall, & Sherwood, 2022). Whakapapa also provides a sense of belonging within whānau, hapū and iwi. Mental health practitioners acknowledge the impact that a lack of connection through whakapapa can have on mental wellbeing for Māori (Durie, 2003). In an affirming article on her thoughts on the derogatory term 'plastic Māori', Tamihana (2023) reinforced whakapapa as being the only qualification necessary to be Māori. Wiapo and Clark (2022) acknowledge the spiritual and metaphysical dimensions in the description of whakapapa as woven strands which link the past, present and future.

Rangatiratanga

The principle of tino rangatiratanga is about sovereignty, self-determination and autonomy. It is about power sitting with Māori and within Māori cultural understandings (Pihama et al., 2002; L. T. Smith, 2017). Within research generally, the rangatira principle asserts that Indigenous intellectual rights are respected and prioritises the collective interests and aspirations of Māori communities. In kaupapa Māori research, rangatiratanga reaffirms challenging of colonial power structures and that Māori communities own their traditional knowledge and have the right to protect it (Walker et al., 2006). The principle of rangatiratanga is enacted within this research through the kaupapa Māori design, including setting up kōrero rather than structured or semi-structured interviews to allow participants to share their pūrākau without over direction from me as the researcher. I have also set up multiple points for member checking which are described in detail in the methodology chapter, such as the review of transcripts and review of initial findings. Pihama et al., (2002) suggests that

rangatiratanga cannot be achieved within an existing Pākehā dominated institution such as a university, a point that requires reflection and thought.

Te reo Māori

The principle of te reo Māori in kaupapa Māori research is centred on valuing our language, for the researcher, the participants and the readers of research (Walker et al., 2006). The use of te reo Māori in research supports language revitalisation, which was explored in detail in the background chapter. Te reo Māori as a foundational principle also recognises using te reo in research to provide depth of understanding to values and concepts that cannot be easily translated into English (Walker et al., 2006). On a practical level, using te reo Pākehā words or providing direct translations of te reo Māori limits the understanding of concepts. From a mātauranga Māori perspective, direct, literal translations limit the sharing of vast the knowledge behind concepts. For example, Matamua (2017) describes the history of the translation of matariki into te reo Pākehā. If taken literally, matariki is often translated as 'little eyes', which can be traced back to a Pākehā historian in 1955, whose interpretation of matariki lacked greater connection to mātauranga. Matamua (2017) did not attempt to make a direct translation but explored the whakapapa of the name 'Ngā Mata o te Ariki Tāwhirimātea' and the origins of Matariki after the separation of Ranginui and Papatūānuku.

By using te reo Māori, I have also been able to further align kaupapa Māori epistemology with the practical aspects of this research through my choices of kupu. For example, I have made purposeful choices, such as having kōrero with participants of my research, rather than interviewing them. This is a subtle difference but recognises more equal power than the words interviewer and interviewee.

Tikanga

Tikanga is another example where the direct translation of a word from te reo Māori to te reo Pākehā leaves a lot of nuances behind, Moko Mead (2016) among others have devoted entire books to tikanga practices. Tikanga is often defined simply as 'custom', referring to our customary Māori practices and protocols, or the application of values that dictates behaviour in Māori society (Moko Mead, 2016). When broken down, the kupu 'tika' means right or correct, therefore tikanga Māori is a focus on the correct way of doing. To act in a tika way requires moral judgement about the appropriate way to behave and act in day-to-day life. Knowledge about tikanga has been embedded through generations, and this generational knowledge of tikanga is threatened as much as te reo Māori has been (Moko Mead, 2016).

Within research, tikanga guides us in how we should conduct ourselves as kaupapa Māori researchers, upholding cultural ethical standards throughout all aspects of the research process

(Cram, 2001). It emphasizes the importance of respect for the rights and dignity of participants and the consideration of the potential impact of research on communities (Hudson et al., 2010). Tikanga can be demonstrated from the inception of a research concept, through taking time for karakia and whanaungatanga, the sharing of results, or seeking permission at different points of the research process and a myriad of other ways (Cram, 2001). The ways that tikanga have been observed for this research are explored in detail within the methods section.

Being an Insider in Kaupapa Māori Research

My position as an insider researcher was introduced in the background chapter of this thesis and is explored further in this section as an important characteristic of kaupapa Māori research. Strategies for managing this position are outlined.

An inescapable aspect of kaupapa Māori research, is the role that the researcher plays as an insider (Smith, 2006, 2012). Within research there are multiple ways to be an insider, including sharing culture, characteristics and experiences, or more specifically being part of the same hapū or whānau group (Dwyer & Buckle, 2009). In Indigenous research, insider researchers potentially hold positions of privilege through the ability to access deeper levels of knowledge. These unique advantages come with significant responsibility (Smith, 2012). Rewi (2014) succinctly summarised the difference between insider and outsider researchers:

> *"In my view, the critical difference between the two is that an insider lives with the consequences of his or her actions while the outsider maintains a safe distance and may not be affected in the same way, nor held accountable at the same level"* (p. 247).

Within this research, I saw myself as an insider, both as someone with Māori whakapapa and as someone who works within the healthcare system. I came to each kōrero with an understanding of tikanga and values, a pre-existing foundation for building authentic and meaningful engagement with participants. The stories of life working within Crown health organisations that participants shared with me immediately resonated, and I was able to inquire about these without requiring additional time spent on initial understandings. Brockie et al. (2023) identified the insider status of Indigenous nurses as an ideal position to understand the position of Indigenous communities and lead change in the health system reform. While an insider researcher is similarly able to build strong relationships based on shared experiences and desire for change, this isn't always necessarily positive (Smith, 2012). Being an insider also requires careful management to ensure that personal biases or assumptions do not overshadow the voices and perspectives of others. Kaupapa Māori approaches have been critiqued because of the potential impact of this (Tiakiwai, 2017), reinforcing the importance of continual self-monitoring to ensure awareness of assumptions.

Reflexivity

Reflexivity is a process of self-reflection, documenting and taking responsibility for own beliefs about the research that is being carried out (Braun & Clarke, 2022). A localised critical theory perspective also encourages us to consider the environments that research takes place in and the influences that power has on knowledge production (Braun & Clarke, 2022; Mahuika, 2017; Smith, 2012). Smith (2012) emphasised how essential constant reflexivity is to manage the difficulties of being an insider researcher. She recommends development of ways to think critically and reflect on processes, relationships and the quality and richness of data and analysis in order to enhance the quality of our work and identify potential sources of bias and influence. Critical thinking and reflection should also acknowledge that as researchers, our own knowledge and beliefs have been shaped by colonial education and upbringing (Mahuika, 2017).

Transparent positioning provides a way to acknowledge colonial influences and also supports robust research, by clearly articulating who I am and my relationship to the research topic and to the participants themselves (Chilisa, 2020). This positioning begins from the first introductory chapter of my thesis and continues throughout where sharing of myself is appropriate. The detail of strategies I used for critical reflection are explored within the methods section.

Reflexivity strategies

Kaupapa Māori researchers are encouraged to engage in reflexivity as an integral part of their research (Mahuika, 2017; Smith, 2006). For me, this has included reflective journalling, maintaining an ideas and brainstorming notebook, post-kōrero notes and establishing a system to track my writing that shows the development and evolution of my thinking and ideas. I purposely separated out my journal from what I refer to as my notebook as I felt that these represented two different types of reflection. My journal has been kept in the traditional sense, with entries marked by date, documenting my thoughts. Where these reflections add value to the research or unpack potential bias, I have included them in the text, labelled as whaiwhakaaro. For example, receiving ethics approval and confirmation of candidature marked a significant milestone where I reflected on what seemed a sudden jump into actually carrying out research.

WHAIWHAKAARO

We've just been talking about when I should do my first interview, I've been thinking about doing a pilot interview, or waiting until after Christmas etc etc… I'm really nervous. Once I talk to a "participant" it's almost like I'm going to be a proper researcher, rather than just someone planning research. Once I start gathering information and talking to people I'll have a responsibility to do something with that taonga, no backing out. J's advice was to just jump off that cliff!!

This entry goes on to talk about a big project I was working on at the time and the frequent mention of needing more Māori leaders in the hospital to make outcomes better for patients. I documented what I thought I might hear in my upcoming kōrero, and concerns about being able to get participants talking without falling back to traditional interview methods. Over the first few pages of the journal, I have also documented key events that occurred for me over the period of my research, including renovations of our home, the devastation of Cyclone Gabrielle, the restructure of Te Whatu Ora and the disestablishment of my role. These events contribute to my self-awareness and knowledge of what I might be bringing into my research.

My ideas book on the other hand has been very freeform, with pictures, mindmaps, quotes, whakataukī and general notes of thoughts to pursue. It sat beside me during kōrero with participants, during the writing process and was pulled out to take notes during or after conversations with research whānau. At a couple of points during the process, I have transferred some of these ideas into my journal, reflecting on where a thought originated and how it has grown.

Tracking writing and version control has been a technique that I regularly use in my mahi and was something that I could bring with me into thesis writing. For me, it has meant that I have been able to follow an idea or thought in my writing, deleting information or cutting and pasting and generally being creative without worrying about losing information, or regretting changes. Through my thesis versions I can clearly track the development of concepts. Figure 4 below provides an example of this.

Figure 4: Version tracking

Version	Date created	Notes:
v1.0	11/2022	Thesis outline created, populated with PGR9 information & ethics application information. Emailed to JD & KW 28/4/23
v1.1	28/4/2023	Document control table added. All other adjustments marked with track changes. Emailed to JD & KW 17/5/2023
v1.2	17/5/2023	Track changes accepted 17/5/2023. Emailed to JD & KW 27/5/2023
v1.3	27/5/2023	Track changes accepted 27/5/2023. Emailed to JD & KW 27/6/2023
v1.4	7/7/2023	Track changes accepted 7/7/2023. v1.3 emailed to JD & KW 3/7/2023. Work focusing on capturing methodology.
v1.5	23/8/2023	Version 1.5 created after methodology feedback from JK. Feedback emailed to JD & KW 23/8/2023. Work focusing on documenting methods and flow between methodology and method

Post-kōrero notes were a reflection of my initial thoughts after a kōrero, capturing what I thought went well, what could have been improved on my behalf, interesting topics that were discussed and reflections on what was shared. The whaiwhakaaro below provides an example of this.

WHAIWHAKAARO

I'm so glad that I asked about her whānau, she mentioned almost in passing during whanaungatanga how important they were to her but it wasn't until about halfway through when I asked her to tell me more about them that she talked more freely (was she thinking that she needed to be 'professional' and talk only about mahi?), she really shone talking about her mokopuna and it came out that making the system a better place for them was a big part of her drive.

Research whānau

Smith (2012) suggested the need for insider researchers to build support systems applicable to their research. My research whānau first introduced in the introductory chapter has been an essential support, encouraging me but also prompting critical reflection and offering opportunities for discussion right from the inception of this research. The research whānau is another concept central to Māori that is a commonly used aspect of kaupapa Māori methodology (Smith, 2012). It is a way of incorporating different voices and perspectives of a variety of Māori communities. My research whānau includes kaumātua, Māori colleagues in the health system, and strong academic Māori voices including my own Māmā. From an insider researcher perspective, this variety of voices also provides a way of reviewing issues or ideas that may have an impact on the research project. The influence and practical working of this will be explored further within the methods section of this chapter.

Overall, the insider researcher in kaupapa Māori methodology has the potential to bring depth, authenticity, and accountability to the research process, ultimately contributing to the empowerment and self-determination of Māori communities.

Kaupapa Māori Methodology

This section describes kaupapa Māori methodology as distinct from kaupapa Māori philosophy and epistemology. It introduces key questions from Linda Tuhiwai Smith (2012) that provide direction for kaupapa Māori researchers and explores the research values identified in figure 3 on page 46.

Kaupapa Māori methodology approaches and subsequent analysis are encouraged to be diverse, allowing differing Māori communities to own and drive the process and represent the "diversity within our people" (Smith & Reid, 2000, p. 14). A similarity, regardless of framework or approach is

the understanding that kaupapa Māori methodology is about a research design that is meaningful and ensures benefits are realised for Māori communities (Smith, 2012; L. T. Smith, 2017; Tipa, 2021). To support this focus on benefit and transformational change, Smith (2012) recommends several questions for researchers to consider.

- Who defined the research problem?
- For whom is this study worthy and relevant? Who says so?
- What knowledge will the community gain from this study?
- What knowledge will the researcher gain from this study?
- What are some of the likely positive outcomes from this study?
- What are some possible negative outcomes?
- How can the adverse outcomes be eliminated?
- To whom is the researcher accountable?
- What processes are in place to support the research, the researched and the researcher? (pp. 175-179)

These questions emphasise the importance of researchers remaining connected to the 'why' behind kaupapa Māori and Indigenous methodologies. Smith (2012) described a distressing history of being researched, of dismissed cultural protocols and unfair policies backed by 'research'. She describes being told things that were already known, and offered solutions that wouldn't work. This was reinforced by kaumātua, who asked in our very first meeting who this research was for.

The tenets of kaupapa Māori research methodology can be immersed in multiple Māori worldviews and are not prescriptive, therefore a systematic inquiry can be difficult to describe (Smith, 2012; Smith & Reid, 2000; Tipa, 2021). As described on pages 45 and 46, I have chosen to use an illustration to depict the interaction between foundational principles and what I have described as research values. These values of whanaungatanga, manaakitanga, aroha, tika, pono, kaitiakitanga and wairuatanga describe my systematic approach to inquiry.

Whanaungatanga refers to the principle of building and nurturing relationships, establishing connections, and kinship (Moorfield, 2005). In kaupapa Māori research, it emphasises establishing respectful and meaningful relationships with participants, community members, and other stakeholders (Bishop, 1996). Whanaungatanga recognises the importance of building trust, engaging in reciprocity, and valuing the interconnectedness between individuals and their communities. Implicit in the action of whakawhanaungatanga is ongoing sharing with participants about the aims, actions and outcomes regarding the research project (Rewi, 2014).

Manaakitanga embodies concepts of nurturing relationships, including providing hospitality and care. It describes a standard of behaviour and is always important, no matter the circumstances

(Moko Mead, 2016). Practically in Kaupapa Māori research, it involved creating safe research environments and inclusive environments that prioritised the wellbeing of participants and encouraged collaboration, discussed further in the methods section (Cram, 2001).

Aroha, tika, and pono represent the principles of love, truth, and integrity, acting with integrity to do the right thing in the right way. Aroha is an essential part of manaakitanga, acting with the thoughts of others in your mind (Barlow, 1991). Tika emphasises upholding fairness, justice, and ethical conduct (Barlow, 1991). Pono signifies truthfulness, honesty, and integrity in the research process (Barlow, 1991). These concepts interact with each other, to ensure that all actions by researchers are in the best interests of Māori.

Kaitiakitanga is a principle of guardianship, stewardship, and sustainability. In kaupapa Māori research, it emphasises the responsibility of researchers to respect and protect the well-being of people, knowledge, culture, and the environment (Cram, 2001). An example of this in this research is the recognition of myself as a temporary guardian of the knowledge that participants have chosen to share. As the researcher, their pūrākau (or 'data') does not belong to me and it is my responsibility to ensure that it is kept safe and that new knowledge is disseminated to benefit Māori.

Wairuatanga refers to expression of a spiritual dimension and psychological well-being that comes from acknowledging our whenua, atua and whakapapa (Came et al., 2023; Carlson et al., 2022; Hape, 2022). In kaupapa Māori research, it acknowledges the interconnectedness and weave of the physical, spiritual, and metaphysical realms. Wairuatanga was not initially recognised as a methodological principle in early iterations of this research. During review and discussion of figure 4, Kaumātua encouraged me to approach the research process in a holistic way and recommended inclusion of wairuatanga. This encouraged consideration of the spiritual dimension implicit in te ao Māori in the pūrākau of leaders. Wairuatanga as a concept is also present within Te Tiriti o Waitangi in article four. It represented a verbal agreement that the range of faiths practiced in Aotearoa, including "Māori custom" would be protected by the Crown (Berghan, et al., 2017).

Methods

This section describes in detail the application of tikanga to this research and the use of pūrākau as a research method. It focuses on the practicalities of research, describing aspects such as recruitment strategy and data collection.

Tikanga

Tikanga as a founding principle of kaupapa Māori research is described earlier on page 48 and is depicted in figure 3 (L. T. Smith, 2017). Tikanga reflects the application of values through practices and protocols (Moko Mead, 2016). Cram (2001) and Smith (1997) described seven guidelines which

guide how kaupapa Māori research ethics can be applied: titiro, whakarongo, kōrero; kaua e takahia te mana o te tangata; kia mahaki; manaaki ki te tangata; aroha ki te tangata; kia tūpato and kanohi kitea. These guidelines express a "process rather than principles or theory" (Cram, 2001, p. 42) and together with the hui process described below, form the tikanga specific to this research.

The meaning of each of the tikanga guidelines from Cram (2001) and Smith (2012) is explained here, with detailed reflections on how these were enacted on pages 60-63. As with other principles described there are points where these process guidelines overlap and intersect.

Titiro, whakarongo, kōrero means to look and listen before beginning to speak. This is reflected in my choice of unstructured kōrero where, as the researcher, I have taken the lead from the participants. I chose not to approach the data collection with pre-planned detailed questions. Kaua e takahia te mana o te tangata reminds researchers not to trample on the mana of people and that upholding the mana of the participants is front and centre. Kia mahaki reflects humbleness. Within this concept, the researcher takes on a position of learner, taking in the information that the participant shares rather than consider themselves as the person with the knowledge. Kia mahaki acknowledges that the research could not proceed without the generosity of the participants. Manaaki ki te tangata describes the process of ensuring the comfort and wellbeing of the participants. It incorporates concepts of reciprocity and a collaborative approach to research. Aroha ki te tangata is about giving respect to the participants, their time, and the knowledge that they bring. Kia tūpato reminds us to be cautious. For a kaupapa Māori researcher, this refers to being politically astute, culturally safe and continually reflective about their insider/outsider status (Smith, 2005, p 98). Finally, kanohi kitea is about putting yourself out there and being seen. It emphasises concepts of recognition, visibility, and inclusivity, ensuring that the contributions of participants, and the participants themselves are seen and respected throughout the research process (Cram, 2001).

Pūrākau

The key kaupapa Māori method I have employed in this research is pūrākau. Participants were invited to share their pūrākau as Māori working in Crown health organisations. Collecting these pūrākau is key to understanding the intricacies and articulating the full scope of Māori clinical leadership work in Crown health organisations, and in understanding Māori clinical leaders' aspirations for support and growth.

Pūrākau are a traditional form of story that provides an understanding of historical narratives. They are one of the key ways knowledge was sustained and are an integral part of iwi, hapū and/or whānau history (Lee, 2009). Lee (2009) recounted how pūrākau were told in Native Land Courts to illustrate a whānau or hapū connection to the land. She also outlined how pūrākau have been

impacted by colonisation, with the synthesising or changing of aspects of pūrākau to suit European sensibilities. Smith (2012) recognised that the reclaiming of pūrākau in research contributes to wider decolonisation efforts.

> *"A pūrākau approach encourages Māori researchers to research in ways that not only takes into account cultural notions but also enables us to express our stories to convey our messages, embody our experiences and keeps our cultural notions intact." (Lee, 2005, p. 8)*

Pūrākau continue to be constructed by individuals and whānau throughout their lives, and are informed by values, experiences, and worldviews. Although pūrākau is an oral tradition, it can continue to provide the stimulus to write, create and research in ways that are culturally responsive (Lee, 2005). Lee (2009) describes the use of pūrākau in areas outside of oral tradition and research, including film making, theatre, written depictions of mana wāhine, art and poetry.

The use of a pūrākau framework within data analysis provides opportunities to uncover meaning from a te ao Māori viewpoint (Davis & Came, 2022; Wirihana, 2012). Examples of pūrākau analysis in research have provided a basis for Indigenising analysis within this research, explored further in the data analysis section below.

Ethics approval

Ethics approval was obtained from Auckland University of Technology Ethics Committee (AUTEC), reference 22/299 (appendix C). AUTEC requested clarifying information following the first application, including further detail of how contact was to be made with first participants, and assurance that during recruitment participants would be passing on information about the research to others that may be interested, rather than providing contact details to myself as the researcher. AUTEC also queried if there had been consideration of risk to the participant's employment or organisation from their involvement. Maintaining confidentiality was essential for some participants, and less so for others. As AUTEC correctly noted, unfortunately it needed to be considered that there was some potential risk to participants should they speak out about negative experiences in the workplace. Calling out instances of racism or unfair employment practices is not the intent of this research. Mitigation of this risk for participants was managed through the confidentiality process, by removing all identifiers (name, age, sex, specific job title, workplace) in publications (including thesis) and presentations.

It was noted during the ethics application to AUTEC that the world of Māori health leadership is particularly small, many Māori leaders know each other. Many participants identified through their kōrero that they were the only Māori practitioners in their teams, making some of the stories easily identifiable. Therefore, participants were afforded the opportunity to omit or change details of

particular experiences or situations that may be identifying. Although readers could deduce that some participants would be employees of Te Whatu Ora, any mention of specific locations or teams was also omitted.

Organisational approval was also sought from Te Whatu Ora, via Te Matau a Māui Research and Ethics Committee (appendix D). This was for two reasons, firstly because I am an employee of Te Whatu Ora, and secondly as the primary provider of Crown funded public healthcare in Aotearoa it was anticipated that most participants would be employees of Te Whatu Ora. At the time of the application, there was no national approach to research approval. This application required demonstration of relevant ethics approval and evidence of engagement with Māori. A reference from Kaumātua (appendix E) was provided.

Recruitment strategy

I purposively recruited 12 Māori clinical leaders who were working, or who had recently worked within a Crown health organisation. It was emphasised in the participant information sheet (appendix F) that participants did not need to be in a defined or designated leadership role to participate. There were no boundaries established around length of time in clinical practice or the need to be in a registered profession, in order to potentially capture Māori leaders such as the rehabilitation assistant mentioned in the introduction chapter. Participants were able to be in designated senior clinical roles or been known as people who are constantly striving to improve the care and clinical practice of themselves and those around them.

Recruitment initially aimed for 10-15 participants by utilising a snowball recruitment technique. Snowball sampling was chosen as a method that can be used for reaching groups of people who may be distributed across a system, such as Māori clinicians working in large Crown health organisations (Noy, 2008). Researchers begin by identifying key participants who fit the study's criteria and then ask these people to refer other participants (Merriam & Tisdell, 2015; Noy, 2008; Tracy, 2019). During the planning of the recruitment strategy, I was concerned that Māori leaders may not describe themselves as someone who should represent leaders in a research project. This humbleness is captured in the well-known whakataukī:

Kāore te kumara e kōrero mō tōna ake reka. The kumara does not boast of its own sweetness.

The use of snowball recruitment mitigated this risk. It allowed participants to identify people who they thought of as clinical leaders, who may not necessarily think of themselves in this way.

A potential limitation of snowball recruitment techniques that was considered was the possibility of a snowball sample being skewed. Tracy (2019) suggests that people will naturally identify other

participants who are alike to themselves. While this is the purpose of snowball sampling, in the case of this research it could have led to limitations such as unintentionally confined professional groups for example, primarily physiotherapists, or primarily nurses. A suggested solution is to recruit initial participants who represent variety within the desired sample (Noy, 2008; Tracy, 2019). This risk was managed through the initial distribution of the participant information sheet to a group that covered multiple disciplines, varying years of experience and varying job titles including unregistered workforce.

It was identified during the ethics application process that approaching potential participants myself would not be appropriate. I have held formal leadership and supervisory positions and wanted to avoid coercion due to any power imbalance. In order to avoid any coercion in the recruitment process, I began the snowball recruitment by first approaching the Research Committee at Te Whatu Ora Te Matau a Māui, who agreed to act as a third party and initially distribute the research information sheet and a brief email (appendix G) to their mailing list and a mailing list of Māori allied health staff (approximately 60 people). This group included Te Matau a Māui Pou Whirinaki (cultural advisors) and Māori health team alongside multiple other professions including kaiāwhina, physiotherapy, occupational therapy, oral health, pharmacy, healthy housing and maternity services. The first participant was attending a year-long clinical leadership training called Ngā Manukura a Āpōpō and distributed the participant information sheet to contacts through this course. Participant information sheets were also shared by an unknown third party to the Kia Ora Hauora Central Facebook page and was shared further from there. Kia Ora Hauora is a National Māori workforce development programme, aiming to increase the number of Māori working in health professions across Aotearoa. Additional recruitment plans had included requesting Māori professional associations such as Ngā Pou Mana (Tangata Whenua Allied Health Association) or Te Ora (Māori Medical Practitioners Association) to distribute recruitment requests, however this was not required.

Relying on participants to make contact rather than being able to approach suitable people, and by not requiring participants to be in a formal leadership role did open the possibility of participants identifying themselves as leaders where this may not necessarily be the case. Because an aim of this research was to articulate the full scope of Māori clinical leadership work, I reflected early on that it was important for me to have an open mind about the different forms that leadership may take, using specific exclusion criteria rather than personal judgement about what makes a leader. By asking people to identify leaders based on the demonstration of values, it was hoped that the right people would come forward. All participants who made contact received a phone call or email

(based on their preference) prior to making plans for a kōrero. At this time exclusion criteria were applied. These included:

- Participants who were my direct report or supervisee
- Positions of leadership where has been no clinical focus or without relevant clinical leadership experience (i.e., working in areas of Crown health organisations where there is no contact with patients such as information technology or finance departments)
- Clinicians whose predominant experience is within specific Māori health or kaupapa Māori services
- Clinicians whose predominant experience has been within non-Government health organisations (NGOs), or private health organisations (such as private hospitals or private practices).

It was intended that if more people than required agreed to participate, participants would be selected based on opportunities to create variation within the sample, however this was not required.

Kōrero (discussed below) commenced as participants were recruited. 13 participants were initially recruited, with one withdrawing after accepting a new role and struggling to find the time required to meet.

Participants

Participants represented a range of professions, including physiotherapy, social work, nursing, and a senior medical officer. Due to the small number of Māori is leadership roles across Aotearoa, specific job titles and designated leadership roles have been excluded from descriptions about participants to protect their anonymity. For the same reason participants have not specifically been linked to locations. They were from various places across Aotearoa, including Ōtautahi, Tairāwhiti, Te Matau a Māui, Te Whanganui-a-Tara and Tāmaki Makaurau. Two participants identified themselves as male, 10 identified as female. Three participants had left their Crown health organisation role; however they described their Crown health organisation employment as recent. Two participants identified Pacific nation heritage alongside their whakapapa Māori, which played a part in their leadership experiences.

Data collection

The philosophical basis for tikanga led guidelines incorporated into this research has been described in an overall capacity in the methodology section above, and throughout the methods section. This section will share in more detail how the tikanga of kanohi kitea, aroha ki te tangata, manaaki ki te

tangata, kia mahaki, kaua e takahia te mana o te tangata, kia tūpato and titiro, whakarongo, kōrero have been demonstrated throughout data collection.

All planning for data collection revolved around the concept of titiro, whakarongo… kōrero (Cram, 2001). Participants were invited to share their pūrākau through an unstructured interview or kōrero with me, in a place of their choosing. Rather than semi-structured interview approaches that contain an interview guide, an unstructured interview starts with an introduction to the area of study and was accompanied by topics to be included in the interview (Chilisa, 2020). My choice of language in referring to these 'interviews' as kōrero is purposeful. I chose to kōrero with participants for its congruence with kaupapa Māori research philosophies, where research is not imposed on participants and is about power sharing and the philosophy of rangatiratanga (Moyle, 2014). An unstructured interview approach allows for flexibility and an ability to follow the thoughts of participants rather than purely the objectives of the researcher. Participants were all offered virtual, phone and in person hui options. Four participants chose to meet in person and seven via zoom, with one participant requesting to kōrero over the phone as she was not confident with technology.

Kōrero with participants was preceded by an initial contact, either via phone or email in order to make some initial connections. It allowed an opportunity for participants to ask any questions prior to a recorded kōrero and gave an opportunity to apply any exclusion criteria.

Each kōrero followed the hui process, a framework developed to guide clinical interaction and facilitate connection between doctors and their Māori patients (Lacey et al., 2011). Although it is a clinical framework, it describes tikanga and process for a hui that is appropriate in situations such as the kōrero intended with research participants regarding their leadership pūrākau. The framework itself also provides a convenient way to describe the tikanga that is generally followed in hui for academic processes such as ethics approval. Aspects of the framework and how it was applied to the data collection process are described below.

Karakia timatanga

At the beginning of each kōrero a karakia timatanga was offered, and in all cases accepted. As a beginner te reo Māori student I had a karakia prepared in advance. Having this prepared enabled me to document it in my ethics application, demonstrating during this process that I had completed necessary planning to uphold tikanga practices. Having experienced the strain of being singled out to recite karakia as the only Māori person in a hui, it was very important to me that I was prepared as the facilitator and did not need to ask this of my participants.

Ngā mihi o te rā ki te tangata e huihui nei

Kia tau te rangimārie

Kia whakatapua tātou me ngā mea

E whakapono ana tātou

Haumi ē, hui ē, tāiki ē!

Greetings of the day to the people gathered here

Let peace be with us

And may we respect each other and what we believe

Mihimihi

The format of introductions during each kōrero was slightly different, depending on the lead taken by the participants. It included pepeha in te reo Māori or in te reo Pākehā and included acknowledging and thanking participants for their time.

Whakawhanaungatanga

Whakapapa o ngā whānau me ngā mahi

Sharing information and making connections beyond introductions and establishing the beginnings of a relationship. In standard western research, the researcher is often apart from their participants and wouldn't necessarily discuss themselves. This is different in kaupapa Māori research, where a reciprocal relationship between participant and researcher is essential. Connections for me during whanaungatanga included conversation based in the healthcare mahi of the participant and myself as easy common ground. There were often a number of connections to be made through who we know in our healthcare work places as well as in the type of work that we do. An example of more personal whanaungatanga with participants included a discussion with N.T. about her grandfather, who is living in Hawke's Bay and is not far away from my own home. Other examples included discussion about common experiences of carrying out research, friends who were working in the same hospital and for those who were based on the East coast, the impact of shared weather events. Chilisa (2020) suggested that interviewing in Indigenous research should privilege relationships people have with each other and the world around them and the whanaungatanga process was an important aspect of achieving this.

He aha te whakapapa o tēnei rangahau?

This was the point where it was identified in the predefined kōrero guide that I would talk about what has led to the research, the relevant aspects of my doctoral journey to date and if appropriate, where guidance has been received from. Although this was intended to be about the background to

the research, this information was primarily covered in the participant information sheet, therefore the conversation on the research background was short.

Points that were prepared to potentially be included were:

- Clinical leadership doesn't require a positional job title.
- I have observed clinical leadership from allied health assistants, new graduate physiotherapists, and from experienced clinicians who provide support to those around them.
- Literature search and work leading up to this kōrero have shown that we know that clinical leaders are important, but we don't fully understand the role and how powerful it can be.
- The aims of the research are to fully articulate the scope of Māori clinical leadership, to determine how our clinical leaders want to be supported to thrive, and to determine what actions could be taken to improve the working environment for Māori clinical leaders to improve retention.

Kaupapa

It was intended that the kōrero at this point would be led by the participants and how they would like to share their pūrākau. I anticipated that through the whanaungatanga process as something arose that interested the participant, the conversation would flow. However, in preparation for the kōrero some key questions were identified in order to provide consistent prompts if required:

- Can you tell me about your clinical leadership journey?
- Do you have experiences of people or events that have supported you to become who you are today?
- What experiences, people or events do you think would have helped you in your journey?
- What could Crown health organisations do differently to effect change in working environments for Māori clinical leaders?

Surprisingly, for each of the kōrero all of these questions were used, with participants showing a desire to provide me with information that would help my research the most. The most important aspect of the kōrero was following the pūrākau of the participants and asking follow-up questions that delved into aspects that they felt were important to share.

Poroporoaki

The poroporoaki involved a winding up of the conversation, such as checking in to see if there were any additional thoughts that participants wanted to share and thanking them for their time. During this time I explained what would happen next and when they could expect to hear from me.

- Reiterated that any information can be removed and participants can choose to remove themselves from the research
- When they can expect to receive their transcript, who is doing the transcribing and the transcribers' confidentiality form
- What the research process is from here, how far through the data collection the research is and when they can expect to receive information about potential themes
- Confirm how they would like to be contacted in the future.

Karakia whakamutunga was offered to each of the participants as a final closing off of the kōrero.

Karakia whakamutunga

Kia tau te manaakitanga

Ki runga ki tēnā ki tēnā o tātau

Kia piki te ora

Kia piki te māramatanga

Kia hoki pai atu, kia hoki pai mai

Tūturu whakamaua

Kia tina! Tina!

Haumi ē, hui ē, tāiki ē!

Settle the care and protection upon each of us

May the health and understanding grow

Return well to other and ourselves

Hold fast to your authenticity! Be firm! Join together! Gather together! Bind as one!

Kōrero ranged from just over 60 minutes to 90 minutes. All kōrero were recorded and emailed to an external transcriber for verbatim transcription. A research journal was kept during data collection, with notes prior to interviews, during (to supplement transcription) and reflections afterwards.

Transcripts were returned to each participant for checking and follow-up kōrero was offered. At this point, I initiated a second discussion about any information that participants might want to exclude. For example, during the kōrero with a participant she discussed experiences specifically related to a very high-level position within a hospital team. After reading her transcript, we had a further discussion where she decided to omit these aspects of the kōrero which made her very identifiable to anyone working in a similar field.

Reflections on Kōrero

Titiro, whakarongo, kōrero

A reflection that came up at numerous points was the difficulty I had in interrupting our whanaungatanga with necessary work such as the signing of consent forms. My thoughts initially were that it would be most appropriate to complete consent information following whanaungatanga, when participants knew me a little more, and felt comfortable that they wanted to proceed. Morally for me, giving participants the opportunity to get to know me and the kaupapa before choosing to share information felt like it should be part of the informed consent process. What this meant however, was that I was unable to naturally follow the kōrero from whanaungatanga to the kaupapa at hand without pausing the conversation. The following is an example of this from my journal:

> *We were chatting at the beginning of the kōrero about her work history, and how she got to her role as … and she said, "the more I got into management the more I realised I was supressing myself". She shared it so freely and I realised that I hadn't done the f'n consent form! Lucky she was so lovely about it, but I felt like such a fumbling researcher – I interrupted her and made it about me and what I needed.*

I used a few different approaches including completing the forms immediately, but the only times I felt comfortable with the consent form was with two participants who I no longer worked with but had known for years. They had seen the pānui, one at work from the research team and the other from the Kia Ora Hauora Facebook post and reached out to me. I was able to address the issue of signing forms before starting with karakia, almost as though I was completing the western part of the interaction before we could relax and allow ourselves to be Māori. It felt so much more genuine and like they really did know who they were trusting with their consent.

Following these reflections on consent, I looked outright for this issue within other Indigenous research. Smith (2012) noted that consent is not a one-off event, but something that should continue throughout the research relationship, and acknowledging that the practice of informed consent can present problems for researchers and for the researched. Fine, Weiss, Weseen and Wong (2000) discussed that the process of signing consent forms highlights a power dynamic and solidifies the roles of researcher and researched. They acknowledge that a consent form can be a positive basis for dialogue and mediation, but that the participant must still sign it.

Kaua e takahia te mana o te tangata

Supporting the mana of the participants was something I was very conscious of, right from the very first contact.

> *I've realised how hard it is to make a judgment on clinical leadership and who is 'included' to participate. Emails are coming through with job titles like registered nurse, public health… there's something important about people putting themselves forward to help me and help research that has resonated with them, what would the impact be on their mana if I said no thanks? You're not the kind of leader I'm looking for?* Personal journal, November 2022.

I reflected that this research was an opportunity for enhancing mana for some of the participants. One of the participants discussed the blow to her confidence after being unsuccessful at interviews for leadership roles, being told that they had employed someone instead who had leadership experience and the vicious circle of being overlooked for roles because of lack of experience, but not being able to get that experience without being given the opportunity. Being able to focus on the leadership role that she was taking for her colleagues, on the ground and that value that that added, felt like a positive unintended outcome from the kōrero.

> *"What an amazing woman, I never would have picked up from her first email that actually said 'if you think I would be suitable' what an amazing leader she was. Years and years of clinical experience and leadership experience, and it was so obvious how she was nurturing everyone around her, up and down."* Personal journal, December 2022.

Another reflection around supporting and keeping safe the mana of participants, was considering the role that I needed to play in taking responsibility for what was presented to them in their transcripts. My approach was rather than sending a transcript and leaving it entirely up to each participant to address any areas of concern, for those who had disclosed stories that I thought really clearly identified them, I highlighted this to them and offered to remove or change this aspect. My approach was based on taking the first step to assist in making participants feel more comfortable with removing information, and it meant they only needed to think about the impact on themselves – because I was already letting them know it would not impact the research. For example, a participant had a difficult experience with her line manager, whom she had named. I removed the name, the job titles and referred to 'the ward' rather than specific location. I asked the participant to read that section (provided a page number) and suggested that I could remove it altogether.

Kia mahaki

Throughout the kōrero with participants I was very aware of the balance between wanting extended conversations and knowing how busy participants were. All participants took time out of their busy lives to have a kōrero with me, in one instance a participant took time out from looking after her mokopuna to talk to me, another scheduled her interview during annual leave so that she could have an uninterrupted conversation and one came into work early to kōrero.

In an ideal scenario I would have liked for whanaungatanga to take place separately and earlier in the process. This idea was discarded because of the time constraints that participants were all under. Taking additional time for whanaungatanga felt as though I was attempting to put boxes around whanaungatanga, which is a fluid and ongoing process.

Manaaki ki te tangata

One of the key ways that I influenced manaaki ki te tangata was to offer participants the choice of where and how we met. The times where I was able to meet in person with participants were very satisfying.

I noted in my journal how nice it was to be in the space of my participants:

> *"I really liked talking to her in her space (a clinic room), I was her guest and I could see how comfortable she felt. She was in charge of the power dynamic more than if we'd met somewhere neutral."* Personal journal, November 2022

I was surprised at the number who were happy to meet via zoom, having anticipated that most would be in person rather than virtual. Zoom offered its own challenges regarding manaaki where I needed to be observant of the lead of the participants, pausing as needed as life went on around them.

I made some choices during zoom hui, including leaving my background unfiltered so that participants could see where I was. One zoom meeting was during the school holidays, I was in a quiet space but still had the kids at home with me. It was a way that I could share myself with participants rather than being a separate researcher.

Evaluation of research

The key elements of ensuring that this research is valid and trustworthy are described in the application of tikanga within my interactions with participants. It is useful however to add to this, clarifying specific techniques used. An essential element of Indigenous research evaluation is consideration of whether the research will do what is intended and bring about positive transformative change (Chilisa, 2020; Cram, 2001). For clarity, the terms validity and trustworthiness refer to research findings being accurate, plausible and relevant (Chilisa, 2020; Creswell & Creswell Baez, 2021).

Whanaungatanga, as discussed earlier in this chapter, is a key value of this research. It is more that getting to know each other, describing a relationship between researcher and participant that is not a fleeting one, finished at the completion of the interview or kōrero (Rewi, 2014). "Prolonged and substantial engagement" recognises the necessity of building relationships through the sharing of

values and a common research goal in Indigenous research (Chilisa, 2020, p. 213). Whanaungatanga ensures that there is a shared goal, that participants know how the research has come about, what they're being asked to contribute and where their voice will go. It helps participants to provide the right information that will be of benefit to Māori and supports production of research that is relevant to communities.

Peer debriefing is engagement in discussions with peers who are familiar with the research or procedures for the study, analysis and findings (Chilisa, 2020; Creswell & Creswell Baez, 2021), and is a function that my research whānau and supervisors filled.

Engagement in reflexivity has been discussed in detail and is another tool to support the credibility of this research, through acknowledgment of the insider researcher. Chilisa (2020) also recommended post interview impressions to record aspects of kōrero such as emotional tone, ease of interview, how whanaungatanga progresses and difficult or surprising moments. As discussed earlier, my ideas book fills this function.

Participant review is another tool I have incorporated in this research design, described in detail in the data analysis section. This review provided participants with the opportunity to hear early iterations of themes in order to ensure that they resonate, and that the content being highlighted is of priority to them. Prior to this, participants were also provided with their transcripts for checking, detailed aspects of which is also described in the data analysis section.

Data Analysis

This section of the methods chapter will describe how data analysis took place. Vitally, this includes steps taken to Indigenise data interpretation, namely use of the pūrākau framework created by Wirihana (2012). Also discussed in this section is the influence of kaupapa Māori research and how this has been incorporated in the data analysis process. I employed reflexive thematic analysis as a base method to generate codes, identify initial patterns and search for early themes (Braun & Clarke, 2017) before applying a pūrākau analysis framework (Davis & Came, 2022; Wirihana, 2012). An overview of the process followed is described and is illustrated in figure 5 below. The section then goes on to elaborate on each step as described in the illustration.

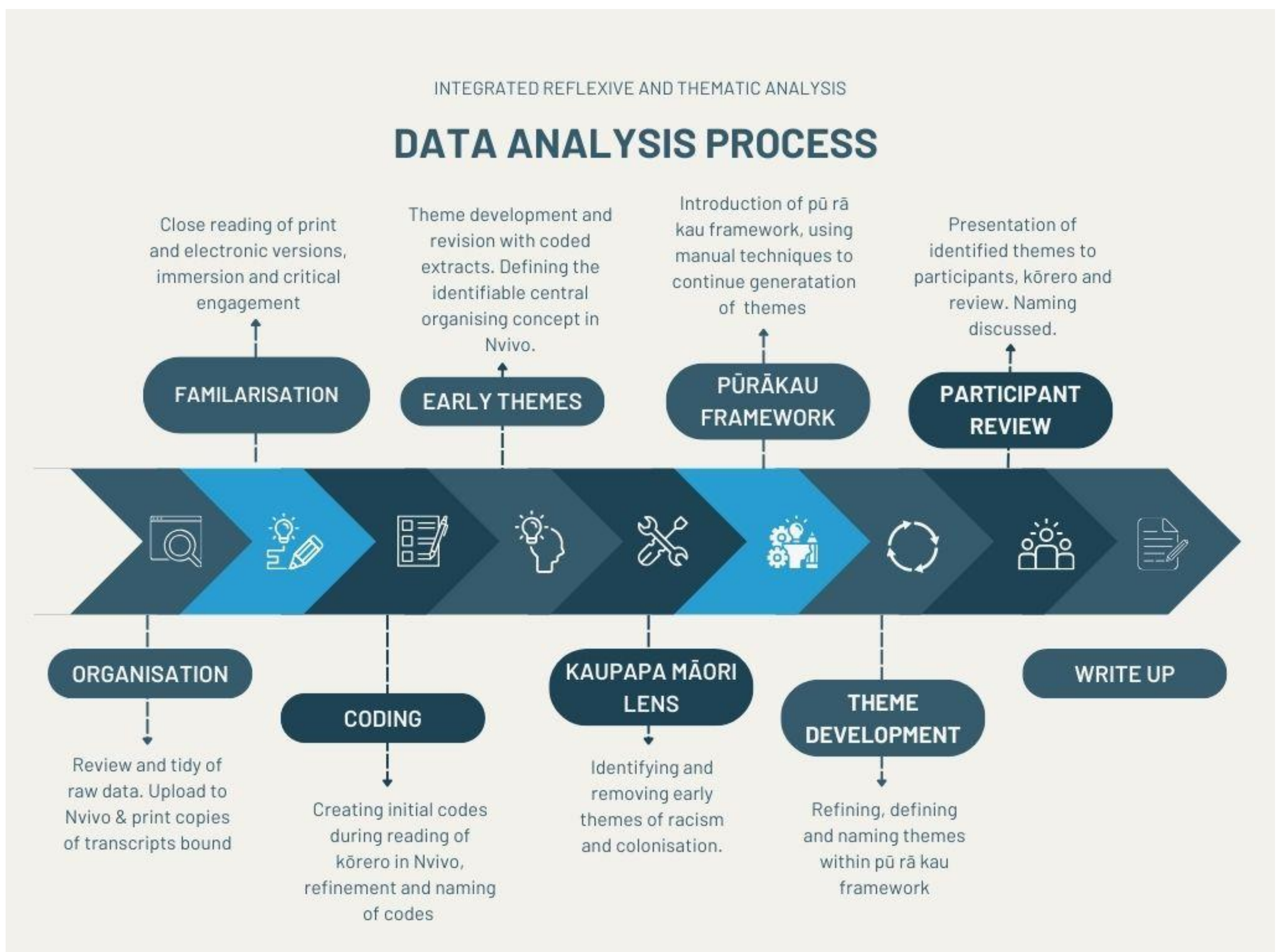
An overview of the data analysis process

This data analysis process utilised both Braun and Clarke's reflexive thematic analysis method (Braun & Clarke, 2022) and Wirihana's pūrākau framework (Wirihana, 2012).

Reflexive thematic analysis was chosen for the initial data analysis process because of its flexibility in application, for its clear guidelines, and most importantly for its congruence with Indigenous

methodologies (Braun & Clarke, 2006). Braun and Clarke (2022) argued that thematic analysis can accommodate a broad range of approaches and aligns with critical theories, providing two examples of Indigenous research that utilise thematic analysis. Tofi (2022) demonstrated successful use of reflexive thematic analysis in Indigenous research, reflecting that he was able to uphold the integrity of Māori and Pacific knowledge throughout his data analysis. Another important congruence between reflexive thematic analysis and kaupapa Māori research is the emphasis on critical self-reflection. Throughout this thesis the importance of recognising the position of insider researcher and reflexivity in kaupapa Māori research has been emphasised. Braun and Clarke (2022) have highlighted frequently that researcher subjectivity is an essential resource rather than a barrier, and that reflection is an ongoing process. This congruence meant that I was able to use both methods of data analysis without compromising either approach.

Figure 5: Data analysis process overview



The pūrākau framework was used in order to understand the experiences of Māori and to support Māori learning and interpretation (Lee, 2009; Tipa, 2021; Wirihana, 2012). As described at multiple points throughout this thesis, each te reo Māori kupu has a whakapapa and depth of meaning that is difficult to translate into te reo Pākehā. Through the process of wetewete, or breaking down kupu into its components, it is possible to gain a greater depth of understanding (Carlson et al., 2022). Carlson et al. (2022) described this further and applied the process of wetewete to the kupu pūrākau:

> *"To wetewete is a process to understand; not exhaust meaning, but rather to unravel the depth of the kupu. Embedded in the praxis of pūrākau is power, creation, life and breath. Pūrākau means to see, imagine, (re)tell truth and live our histories. Pūrākau is our breath; the original tree of life, that takes our carbon dioxide of living and turns it into oxygen, filling our hearts, and minds with energy"* (p. 5).

Wirihana (2012) developed the use of pūrākau as an analysis tool in her doctoral research, describing a similar process of wetewete, breaking down the origins of pūrākau. She described pū as source, rā as enlightenment, ka as past, present and future, and ū from within. These separate components provided her a basis for development of themes within her doctoral studies. Davis and Came (2022) more recently employed this model to support analysis of pūrākau gathered from occupational therapists, naming it a pū-rā-ka-ū analysis framework (p. 4). They utilised a critical Māori advisory whānau to provide advice on the meaning of each component to weave it into their research, defining pū as the source of desire to be an occupational therapist, rā as inspirational experiences that provided enlightenment, ka as past experiences that impacted future aspirations and ū as the source of sustenance.

The application of pūrākau as an analysis method for this research follows the wetewete of Carlson et al. (2022). Pū can be understood as the source or to originate, rā is the sun, enlightenment, and the Tamanuiterā, representing life and solar energy, while kau in this context means without hindrance, unreservedly and simply (Carlson et al., 2022, p. 5). Within te reo Māori tohutō mark long vowels and change the meaning of kupu, for example keke means cake, kekē is a verb to creak, and kēkē as a verb is to quack and as a noun is armpit (Moorfield, 2005). The u used in pūrākau does not incorporate a tohutō, therefore I have utilised the descriptions provided by Carlson et al. (2022) of kau, rather than separately ka and ū as described by Wirihana (2012).

In reviewing studies that had used a pūrākau framework for analysis, both authors appeared to effortlessly move from full transcripts to development of themes without any messiness, confusion, or evolving iterations between the phases. For example, Davis (2020) described colour coding

themes that aligned with her pū rā ka ū method. As a researcher new to kaupapa Māori research, it was evident to me that a data analysis approach with clear guidelines such as reflexive thematic analysis would provide a useful stepping stone into a more fluid Indigenous approach.

Reflexive thematic analysis requires regular and routine reflection on assumptions, expectations and actions throughout the data analysis process (Braun & Clarke, 2022). This is congruent with kaupapa Māori research approaches which encourage self-reflection and critical engagement with the research process in its entirety (Smith, 2012). My reflexive journalling began before the first interview and has continued through the data analysis and write up process. My research whānau have also played a part in the data analysis process. As with earlier chapters, where appropriate excerpts of reflections and the influence of my research whānau have been included below.

A goal of this research is that the philosophies of kaupapa Māori research clearly flow through each aspect of the process. The use of both a reflexive approach and a pūrākau framework supported this goal.

Managing and organising the data

As outlined above, all transcripts were audio recorded and emailed to a transcriber by a link to a google drive audio file which required the link to access. The transcriber had completed a confidentiality agreement (appendix J), and all links were deleted at the completion of the work. Audio recordings in person were via the record function on my phone, and zoom was chosen for the secure meeting recording function. Although video recording was available, in all cases only the audio was sent to the transcriber. For the participant who requested a phone call rather than virtual hui, the call was made on speaker phone with the recording made separately on my mobile phone.

On receipt of the transcripts, I reviewed the audio file and transcripts together. Transcripts were generally very accurate, with some revision and amendment required where te reo Māori was used. As transcripts were verbatim, I spent significant time tidying these. Initially I had intended tidying to involve removing only major conversational fillers such as ah and um, however as I continued reading, I realised how often other conversational fillers were used, in particular 'like', 'sort of', 'yeah, nah' and 'you know?'. Tidying also involved removing identifying information such as very specific location descriptions, job titles, names of colleagues and names of workplaces or wards. Participants were allocated initials, rather than pseudonyms.

When I emailed transcripts back to participants, I included the original verbatim transcript in addition to the clean version. All original transcripts have been saved. Any removal of information to protect the confidentiality of participants was highlighted to them in my email alongside page numbers where necessary.

For ease of managing data, Nvivo software was used to support the storage and management of data in the form of transcripts.

Familiarisation

Familiarisation with data occurred through close reading of transcripts, reviewing of audio files and note taking. I found it particularly helpful to review data in different formats, reading the electronic word documents, having these printed in hard copy and reading the electronic Nvivo copies. Braun and Clarke (2022) caution that familiarisation requires critical engagement with the data, actively assessing and becoming involved as opposed to just taking in information. After printing transcripts I bound them together in a book format as a way of beginning to look at the data as a whole. Printing allowed me to begin actively writing notes on the pages, highlighting and noting interesting points.

Coding

Data was coded in Nvivo, using an inductive orientation where I began with the raw data as my starting point (Braun & Clarke, 2022; Thomas, 2006). Each iteration of coding was exported from Nvivo to word and saved, to enable me to go back over the process and reflect on each step. I systematically read through each transcript, electronically highlighting data of interest and assigning it a name. I approached the first iteration of coding very freely, thinking about the data itself rather than the careful naming or descriptions of codes. In the next iterations, where I read through each transcript again, I began to refine initial codes, thinking more deliberately about naming and creating descriptions. Figure six below shows a screenshot of the point between the second and third iterations of coding where descriptions are beginning to be developed. The first step resulted in 33 individual codes. By the time I felt that coding was completed after multiple reviews, there were 23.

Figure 6: Coding Iterations

Name	Description
Influencing change	
Leadership teaching & training	
Marae	Roles on the marae, being on the marae
Other Māori leaders and role modelling	Inspirational leaders, visible leaders, demonstrations of Māori leadership
Patient care	Including relationships, advocating for patients, wanting good patient outcomes
Personal connections	Important connections and relationships. Includes instances of whanaungatanga
Professional development	Professional development in general, not related to leadership specifically
Racism	
Reward	Positivity, good experiences, notes where participants have been happy with how things turned out, feeling satisfied
Supervision	Supervision for staff, includes cultural and clinical supervision
Support and mana enhancing	
Te Reo Māori	Speaking Te Reo, or feelings about Te Reo
Values	

Figure 7: Coding Iterations continued

Advocating for Māori clinicians	Improving things for Māori in the workplace
Allies	Where participants identify allies who provide them with support (including accessing something, giving support to work a different way, advocate etc)
Being Māori	Reflections on being Māori
Being the only one	The only Māori in a situation (a workplace, at a meeting, in the room etc). Any feelings of isolation added here too.
Challenges, restraints, barriers	Areas that participants find challenging or difficult
Challenging people	Challenging others to be better, challenge for equity, or challenge for the benefit of patients
Clinical practice & leadership	Times when clinical practice and clinical leadership interact
Collectivism	Instances of working together as a team, not being alone, working for other people not yourself
Colonisation	Mentions of colonisation (but not necessarily racism)
Cultural load	Feeling lent on more than non-Māori, higher expectations, or doing more because of being Māori

Searching for themes

In searching for themes I utilised Nvivo to support easy manipulation of codes, dragging groups of quotes from transcripts or entire codes from one place to another, or to multiple places. The initial process for me involved grouping codes that clearly shared meaning, for example grouping formal study, professional development and leadership teaching and training under learning. I also made use of manual techniques, using printouts of codes and sorting them into different piles to see where they might be able to sit differently or be amalgamated. At this point, I had 14 initial emerging themes identified, which are shown in table 2 below. Braun and Clarke (2022) describe topic summaries, where codes are united around a topic rather than a deeper meaning, and challenge researchers to be more reflexive and move past these topic summaries. In reviewing and reflecting on these 14 emerging themes I was concerned that what I had produced was closer to the description of a topic summary, than a theme. With this doubt in mind, I persisted in numerous iterations, changes and reflective moments. For example, in an early iteration I utilised te reo Māori kupu as a way to create themes, however I discarded this work after reviewing and realising that I was at risk of unintentionally attributing new meaning to the pūrākau that was not originally there. What I eventually realised by trialling and discarding attempts at refining themes was that by grouping codes such as formal study and professional development under learning as described above, I had data organised into meaningful but manageable chunks. I decided that this was the point where I would be able to apply my pūrākau analysis approach, to find that deeper meaning with a te ao Māori lens.

Table 2: 14 emerging themes

Name	Description
Learning:	Learning, different ways that we learn and support others to learn, experiences of learning
Formal study	Experiences of studying - degree or career advancement
Leadership teaching & training	Things that people do to learn about leadership
Professional development	Professional development experiences, requesting professional development, the role of professional development in clinical practice. Not formal. Lots of negative experiences (being declined PD)
Allies	Where participants identify allies who provide them with support (including accessing something, giving support to work a different way, advocate etc)
Being Māori:	Reflections on being Māori, he Māori ahau
Bringing Te Ao Māori	Bringing aspects of mātauranga Māori to western spaces
Taiao	The environment that we work in, the wairua around us
Te Reo Māori	Speaking Te Reo, or feelings about Te Reo
Values	Te Ao Māori values or personal values (or both!)
Care for self	How people take care of themselves and their wairua
Challenging processes	Examples of successfully challenging established processes to achieve better results for patients or other staff
Cultural Safety	Thoughts about cultural safety - for Māori kaimahi
Influencing change	
Leadership thoughts	Thoughts and comments from participants about leadership
Examples of clinical practice & leadership	Times when clinical practice and clinical leadership interact

Name	Description
Patient care	Including relationships, advocating for patients, wanting good patient outcomes
Personal connections	Important connections and relationships. Includes instances of whanaungatanga
Collectivism	Instances of working together as a team, not being alone, working for other people not yourself
Reasons why	Positivity, good experiences, notes where participants have been happy with how things turned out, feeling satisfied
Systemic Issues:	
Being the only one	The only Māori in a situation (a workplace, at a meeting, in the room etc). Any feelings of isolation added here too.
Challenges & barriers	Areas that participants find challenging or difficult. Ārai - to obstruct, hinder, block out, prevent
Colonisation	The impact of colonisation
Cultural load	Feeling lent on more than non-Māori, higher expectations, or doing more because of being Māori
Racism	Experiences and thoughts about racism, personal and institutional
Whakamana:	Give effect to, empower, validate. The ways that we become leaders
Other Māori leaders and role modelling	Inspirational leaders, visible leaders, demonstrations of Māori leadership
Support and mana enhancing	Providing support to other Māori staff, building their mana
Whānau	Importance of whānau, whānau support, or whānau role in supporting patients

Pūrākau framework

I reviewed the initial 14 topic summaries against the three components of pū·rā·kau. The consolidation and interpretation in this stage continued along the reflexive thematic analysis process. It is important to note that this aspect of the analysis took significant time, however the three components offered me anchors to start pulling interpretations together and look for deeper meaning as opposed to linking common concepts. Continued reflection involved prompts, including frequent review of what participants wanted others to know. Appendix K provides photographic examples of the manual analysis processes used, including mindmaps with each anchor in the centre, and printing and arranging codes under different headings. These manual processes allowed me greater flexibility than purely utilising electronic methods.

From 14 topic summaries, I was able to establish eight themes outlined in table 3 below.

Table 3: Pūrākau framework and early themes

Anchor	Wetewete	Theme
Pū	A source, origin, foundation, centre, core, hub.	Foundations of Māori leadership. Why we do what we do (the source). Strengthening foundations through learning.
Rā	Sun, enlightenment, life, solar energy. Rā is linked with the atua Tamanuiterā, relating to strength and ability to bring warmth and light into the world. Rā is also connected to good health, hau-o-rā, health from the breath of the sun	The inspiring light of leaders. Strength, light and energy from being a whole person.
Kau	Without hindrance, unreservedly, simply.	I am who I am (determination). I am aiming for that lofty mountain. Success needs

The expression of a kaupapa Māori lens in data analysis

I have identified that this research has its roots in kaupapa Māori philosophy, set within localised critical theory. Essential to data analysis was determining how a critical perspective should be approached and documented without overshadowing the wisdom and strength present in pūrākau shared by participants. However, fully understanding the societal contexts and day-to-day realities of

the people participating in this research can create space for facilitation of social change (Brewer et al., 2014; Cram, 2001; Pihama, 2001; Wilson, Barton, & Tipa, 2022). In the case of this research the clear societal context is the western dominant structures of Crown funded healthcare in Aotearoa. There is well known and substantial research into the institutional racism that is now acknowledged in the health system and impacting the health of Māori, described in detail in the introduction to this thesis. This is not the focus of this research; however it is important to acknowledge.

There was clear description from each participant of barriers that they face, including institutional and interpersonal racism, therefore I decided to remove these factors from the themes, and identify them instead as a context that participants were expected to work within.

By calling out this context separately, it created space for data analysis to focus on areas that have not been extensively researched and highlight development of mātauranga in Māori leadership. By placing it upfront, it allows the presentation of findings to stay true to kaupapa Māori philosophical perspectives.

Participant review

Participant review and member checking are used frequently in qualitative research (Creswell & Creswell Baez, 2021) and are methods of evaluation that are innate in kaupapa Māori methodological ideals (L. T. Smith, 2017). In participant review, participants are engaged with raw data and in emerging analysis through the researcher seeking their whakaaro. During the data analysis process, examples of early coding and the draft themes were presented to participants for discussion. Participants were asked to confirm if this made sense and aligned with the intent of their kōrero. Only participants who had indicated that they were happy for follow-up kōrero were contacted via email invitation.

L. T. Smith (2017) notes that dialogue with participants continually informs kaupapa Māori research and is part of the "social realities for researchers" (p. 52), however it was essential to find the right balance between respecting the time of participants and my research whānau, and getting enough input to ensure that they could see themselves in the findings and results. While I would have loved to have frequent discussions with participants, this was not possible.

During participant review, the eight draft themes from table 3 above were presented with a verbal description and a number of supporting de-identified quotes. We met as a group, with eight participants deciding to take part. The review was recorded but not transcribed.

In addition to presentation of the draft themes, there were three areas that I wanted to have participant input on:

- Were they comfortable that I had extracted information about racism, presenting it as a context that Māori leadership operates within rather than a theme or an outright finding of the research?
- I identified that I wanted to use more te reo Māori when describing themes and their meanings, but that I felt hesitant because I am still a beginner te reo Māori speaker. What was the whakaaro of participants about this?
- When I present this information in the future, what would they like me to prioritise?

Participants identified that they agreed with the initial themes and that they were happy for these to continue being developed. There was discussion about the use of te reo Māori within my thesis. Participants encouraged me to use te reo Māori as much as possible, however also indicated that it was important that I had support to do this. One participant shared an experience of having her te reo Māori criticised during a dissertation examination and shared the negative impact that this had on her confidence. Interestingly, participants were happy for me to make the final decision on prioritisation of information, identifying that I might need to make changes depending on my audience.

In the early stages of the research planning, I had intended that data analysis would also be guided and influenced by kaumātua. However, when I discussed in a catchup where I was up to and what the next steps should be, I was advised "haere tonu girl, you've got this". The kaumātua guiding this research felt like there was no need for his input. On reflection, what I was actually seeking was someone to back me up, when I needed to have confidence in my process and whakaaro.

Table 4: Final themes

Pū	**Foundations for leadership** - Authenticity - Strengthening foundations
Rā	**Whakamana** - Awhi and tautoko
Kau	**Grit and determination** - Creating ripples - Bravery

Kupu Whakatepe

This chapter has described three key sections, including an introduction to kaupapa Māori, a description of kaupapa Māori research and kaupapa Māori methodology. It recognised the distinct differences and interconnectedness of kaupapa Māori philosophy, epistemology and methodology. In the absence of a prescribed and defined process for the application of kaupapa Māori research, this chapter presented an illustration of how I envisaged foundational principles and research values relating to each other. I discussed the implications of insider research within kaupapa Māori methodology and introduced reflexivity and the research whānau as important functions in supporting critical reflection.

The methods employed in this research were explored, putting into practice the values and principles described. It described pūrākau as a method of data collection and discussed data analysis with influences from kaupapa Māori research.

The following chapter will describe key findings, presenting three themes of foundations for leadership, whakamana, and grit and determination. These themes are explored with the voice of Māori clinical leaders at the forefront.

FINDINGS

In this chapter, the findings will be presented in four distinct sections, the context of colonisation and racism followed by the three themes. These themes were generated from the pūrākau analysis framework and include foundations for leadership, whakamana, and grit and determination. These themes and subthemes are described in table 4 above, on page 77.

Each and every participant discussed confronting experiences of working within western Crown health organisations, dealing with racism in its various forms and the ongoing impact of colonisation. Therefore, the first section outlines the thoughts of participants about the environment that they work in. It stays true to the critical theory whakapapa of kaupapa Māori research, calling out racism and acknowledging up front the day-to-day realities for Māori clinical leaders to facilitate change without allowing these factors to overpower the mātauranga of participants and their pūrākau.

The subsequent three sections are presented in alignment with the pūrākau framework that guided analysis. Components of the kupu pūrākau, as outlined in the previous chapter, provided direction and a way to search the data for themes from a mātauranga lens. These findings focus on elevating the knowledge and strength that Māori clinical leaders have shared, articulating the full scope of Māori clinical leadership, and understanding their aspirations for support and growth. Findings are all purposely centred around direct quotes from participants, recognising the words of the participants as taonga that have been gifted to this rangahau.

The contexts of colonisation and racism

Without exception, participants all described working within environments where they commonly experienced racism in a variety of forms. Working in Crown health organisations meant that feeling like the 'other' and that racism was part of their everyday lives.

In a very thought-provoking description, T.U likened big institutions to the scary elephant graveyard in the animated Disney film The Lion King (Allers & Minkoff, 1994). In the film, the character Simba asks about a shadowy boneyard that he can see in the distance and is advised that it is dangerous, and he should never go there. He and his friend Nala go anyway and need to be rescued and brought back to safety.

> *I think about the Lion King right and Simba and Nala. He takes her to the bone yard and in a lot of ways public or large institutions can be like that for us, for anyone who's left of centre. – T.U*

This comparison gives instant images of being somewhere that you know you shouldn't be, and of not belonging to the point of danger. It manages to encompass the overwhelming size of our

institutions. T.U acknowledges that this isn't just an experience for Māori, but for anyone who does not fit into the norm.

None of the descriptions from other participants do anything to dispel this metaphor of the dangerous boneyard. Institutions were referred to as hostile and unsafe, and somewhere that R.D identifies that she would never work again. When considering working in a scary elephant graveyard, this assertion is very understandable.

> *I think it becomes such a hostile work environment there's so much institutional racism. That it can be a really hard environment to work in. Even we had our first, well first since I've been here in probably 10 years, wānanga that was only offered to Māori kaimahi by Māori for Māori and we had Pākehā, you know, I got a phone call voice mail on the weekend that there's Pākehā complaining that it was racist that they weren't invited. – W.A*

> *I will never work at the hospital again ever. Even though they need Māori nurses but man, that, that nearly ran me out of nursing that did. I found this, she's from India, she was a migrant nurse crying in the toilet and she thought, she felt like she was an inadequate nurse and I was no, no, no love it ain't you. It's the system. – R.D*

> *I know for a fact that my colleagues in other health professions have, sat in some really unsafe spaces where, actually they probably didn't even want to put their hand up for that role, they've found their self in themselves in this, in this space where they're like oh god. No one wants to listen, I'm the unpopular person with the unpopular opinion and yet they wanted me here to begin with and I don't even want to be here. – N.T*

A.P had similar kōrero as those above, succinctly describing some of the issues that she comes across frequently in her mahi.

> *Discrimination, bias, stigma, bullying and all the actual reality of what our healthcare system looks like as a Māori nurse caring for anyone in our health system… tikanga stops at the door. Culture stops at the door and those who have it struggle to navigate through it in the system. And that's rough to hear. But it's not wrong. – A.P*

A.T and W.A discussed in different ways their attempts to change the system. These included day-to-day workplace changes such as introducing aspects of tikanga into their workplaces, and service wide changes such as prioritisation of patients of Māori descent. Neither seemed to have much hope at points within their kōrero, with A.T describing tiring efforts where she felt alone despite hearing that there is a desire for change.

I feel like (it's) lip service, there's been many lip service things, where "we must do this", "we need to do that", "we need to incorporate". So I'm like okay, well here's an opportunity, I can help, this is what we can do. And then, it just feels like I'm pushing a wheel, pushing a cart forward that nobody, nobody else is on the waka and I'm paddling alone! I realised some of these people are not in this waka, they'd rather stand on the shore! – A.T

With a similar sense of fatigue, W.A also spoke about the amount of time that it will take to make system wide change for patients and kaimahi such as elimination of interpersonal and institutional racism.

I don't think, like we might make small steps but I think like for there to not be institutional racism, here I think it will take like 40-50 years and for staff not to be racist you know. That's a long time away as well for every staff member to have an understanding of bias and racism and, I can't see that. – W.A

Within kōrero about the environments that Māori leaders work in, was discussion about the difficulty of getting access to appropriate cultural and leadership training and resources, in a clinical setting where clinical competence takes precedence. T.B discussed the difficulty of asking for training that sat outside of usual clinical mahi and being turned down because he'd already had his allocation of training. W.A shared her thoughts that leaders in Crown health organisations need to consider individual kaimahi development needs, as opposed to everyone receiving the same allocation of training. She suggested that as Māori clinical leaders take on additional cultural responsibilities, they should receive higher training allocations, likening this to outdated thoughts of equality, where all patients should receive equal services.

That was because we were having equality in terms of training opportunities not equity for staff so I think one of the ways that you keep people is to offer them more leadership training or professional development, that you put more resources into our Māori staff so they can grow into excellent practitioners because our Māori whaiora and whānau actually need expert clinicians rather than new graduates. – W.A

A.T discussed putting in the effort to learn her language, lost through colonisation and how the te reo Māori training facility accommodated her always being late to class, because the health organisation she worked for was inflexible.

…my classes actually were at 5o'clock and I finish at 5o'clock so I was late by half an hour to every one of my classes on a Thursday night but they were absolutely okay with that. It became a problem when I did Level 4 because the first part of Level 4 was doing hui

whakatau and the people in the class did that. But my class was amazing and they understood where I was coming from, how I was driving across… and that I would be there as close to 5.30 they knew it because I came in at about the same time every time so they would just do other like revision of home work and then start the class a half an hour late so that I could participate in that part of it because it was it was part of the assessment. So it was not supported. It could have been. – A.T

It was clear that the efforts to learn te reo Māori were not valued or seen worthwhile enough to allow for time away from work.

S.W found herself in a difficult space where she was applying for formal leadership roles and being declined because she didn't have any recognised leadership experience or qualifications, but also having applications for leadership courses declined.

…if I put any training through it's got to be relevant to my, my role today. And my, my team leader would question well what do you want, what do you want that for? How is that going to be relevant? You're not a team leader, you're not a supervisor. So how can you advance? We're in a box… we can't even get into the training. There is no path forward. There's a block in the road. - S.W

S.W spoke about this terrible cycle more than once during our kōrero. She described not feeling good enough for recognised leadership roles alongside feelings of needing to be the one to support Māori patients and as though the cultural safety of the entire service was resting on her shoulders. Throughout this kōrero was a sense of unfairness in that the leadership function that S.W was providing was not being recognised. The lack of hope and sense of fatigue was very similar to that described above with W.A and A.T.

Both T.B and N.T spoke about the difficulty of asking managers for support, funding, or time away from mahi for non-clinical or outside the box training. T.B's kōrero included the conclusion that because he was continually being turned away for development that he felt was vital, it was easier to stop asking. The straightforward inference here is that culturally based development was not valued by managers in Crown health organisations or was prioritised lower than training they deemed clinically relevant. In her role and frequently mentoring kaimahi Māori, N.T recognised how difficult it can be to approach a manager or service and ask for help.

If they're actually coming forward and letting you know what they need as Māori clinicians in order to develop and grow. If they've actually come to you and told you, then they've already jumped the first hurdle, it's already taken a lot of courage for them to come and tell you

what they need so let's honour that courage, and, and honour what they need and actually listen to it and deliver on that because time and time again you get young, health professionals coming through and saying, yeah I asked for that but they wouldn't give me the time to go and learn my own language. – N.T

She described her own most recent experiences of non-Māori leaders who default to saying yes to her requests or ideas, preferring to give her unconditional support and work out the practicalities at a later stage. Although this did not apply to all of the environments that she worked within, this supportive space conjured images that are different to the norm and N.T recognised in her kōrero how unusual this was and how lucky she is.

In contrast, T.U talked about the impact of the constant battles with racism and working within western bio-medical spaces on his colleagues and friends. He surmised that the continually hostile environment had shaped some of his Māori and "left-of centre" workmates, leading to them being quick to jump to a fight and to find fault. He reflected about this and his own decisions to take a gentler approach in his actions as a leader, which are grounded in his upbringing.

… we're all fruits of the soil and the winds and the tendering that we've had up until that point… there were those tensions right between am I just, have I lost my way here? Have I forgotten who I'm here for and, and what I'm here for? And so, those things I think are inevitable when Māori work in a system that's been profoundly, fundamentally racist. But I think for me, having a solid grounding not only with my colleagues, not only within my Māori team, but just that hope. – T.U

The examples below represent the casual mentions throughout all kōrero about colonisation and the personal impact that it had had on participants and their whānau. Participants discussed being disconnected from their culture, including their language and their whānau. This discussion wasn't in response to a question but shared freely and recognised as part of everyday life.

My mother grew up in a time where you know it was instilled with her that you should become Pākehā because it would be better for you. – S.W

My own father who never learned te reo Māori because his dad didn't believe that that was a valuable language to learn when they moved from the marae… – A.T

I had a lot of hurt. I've come from the era where you weren't good enough, being Māori is not going to get you anywhere and I was lost. – N.Y

At the forefront for two participants, were their experiences of not looking like how the system and Tauiwi expected them to look as Māori. They both felt that their appearance exposed them to conversations involving overt racism because others perceived them to be of a Tauiwi ethnicity.

> *I feel like I hear more casual racism because of how I look. People feel like they're allowed to say those things in front of me. – W.A*

> *And then the other one, I don't know if you've ever experienced it but people that will openly talk, quite racist around you because they presume, you're not Māori and it's hideously offensive. You know when you end up just being in all these funny spaces where, things are happening, and people just aren't aware, and you don't know how to deal with it either because you're just awkwardly in the space. I think generally I was perhaps an incognito Māori in the room if you know what I mean. – A.T*

It was something that other participants empathised with and something that they recognised as having an impact on whanaunga around them. A.P discussed her teina, who looked quite different to her, joking about her Māmā running out of ink by the time she got to her third pēpī. O.D talked about Patupaiarehe, who were fair skinned fairy-like creatures of old pūrākau and how this reference supports Māori who don't fit stereotypical physical ideas. She also talked about her mokopuna, who were fair, but being brought up knowing their whakapapa.

> *… the reality is for a lot of our babies it's not going to be the colour of their skin it's going to be what they feel within their hearts. – O.D*

O.D and W.Y described the experience of stereotyping based on appearance from two different perspectives, being too Māori for some spaces or people and too white for others. For W.Y this juxtaposition included patient perspectives, not purely other kaimahi.

> *I get it from both. You're either not Māori enough or you're too Māori. You know you're either damned if you do or you're damned if you don't, even with patients and whānau you know? - W.Y*

> *I was too Māori for some people and too white for other people. – O.D*

A.T described the impact of this problem in terms of being viewed as authentic by the managers around her. She went on to kōrero about how Māori are viewed in society and the importance of recognising Māori diversity for allocation of resources.

> *I became the token Māori! And I'm also not good enough half the time. You know so for a very long time, they would get people from Māori services to participate in interview panels.*

And things like that because they needed a Māori on the interview panel and I'm like hello?! Hello?! I'm over here! I know I don't look it. – A.T

Seeing all of these examples in the media where people are saying I'm not Māori enough and I'm a plastic Māori and all these things and I'm like hang on, but we are so diverse. We're saying that we need to tailor things to Māori but we're not even identifying who our Māori are necessarily because we are looking for the Māori that look Māori all the time. - A.T

These whakaaro below capture descriptions of a lack of confidence that comes from insecurities in self-identity. As described earlier, participants identified the need for many Māori to embark on journeys of reconnection because of the impact of colonisation on their whānau. This perception of what being Māori enough means, added to the complexities of self-identity.

I think, Māori that have grown up, in te ao Māori with tikanga Māori are very happy to put their names forward. Because they know the importance of, sitting at the table. I find those that haven't grown up with te ao Māori and are on a journey, ah, they won't purely because they're dealing with stuff where they don't feel Māori enough to, to be the Māori representative in these spaces… in my mentoring roles I'm, you know just I'll sit next to them and I'll go, don't think like that, there's no such thing as Māori enough you either are or you aren't! – N.T

For me feeling Māori, I've always been inadequate, I felt inadequate and some people are quite surprised. – W.Y

There are very few positives to be found in discussion about working surrounded by institutional racism. T.U however spoke in an inspirational way about learning about himself as a leader in a space with others who were confrontational and quick to act in a certain way because of their environment.

I found my leadership style, within an eco-system that I could of quite easily have been swallowed up. And interestingly for me so many of my learnings came from being in and around a leadership style that was contrasting to me, to mine. And so, again maybe that's that optimism maybe that's that sort of matriarch teaching, showing me the importance of whakamana, manaakitanga but recognising that it was such a, at times really ugly space but I was still able to glean so much positive from it because I found, well cool ka pai, that's not how I want to do things, so awesome thank you for sharing that lesson with me. – T.U

This section has utilised the whakaaro and kupu of Māori clinical leaders to describe the everyday environments that they work within, acknowledging the power dynamic within Crown health

organisations. Establishing and calling this out at the forefront allows space for the following themes, identified through the pūrākau framework to focus on adding to the body of knowledge about Māori clinical leadership.

Pū

This section elaborates on the theme and subthemes related to pū. As established earlier in descriptions about the pūrākau analysis framework, pū is the first of three breakdowns of the kupu pūrākau and relates to foundations and origins. The theme of foundations for leadership has two sub-themes, authenticity and strengthening foundations. Foundations for leadership explores elements of tikanga practices, everyday life experiences and the strong role-modelling within whānau and the influence these elements have on Māori clinical leadership. The sub-theme of authenticity speaks to the value that participants place on acting authentically as Māori and working in places where they can be themselves. The sub-theme of strengthening foundations recognises the importance of personal and professional development to grow Māori clinical leadership. It explores ways in which participants currently strengthen their clinical and leadership skill and knowledge, highlighting both what currently happens in practice and what Māori clinical leaders feel needs improvement. Kōrero from participants contribute to an overall understanding of the origins and foundations of Māori clinical leadership.

Foundations for leadership

Participants spoke about the foundations of Māori clinical leadership arising from te ao Māori and the way that tikanga and whakapapa shapes the actions Māori clinicians take as leaders. They identified that their leadership practices have been anchored in Māori culture and determine what makes Māori leadership stand out. Examples include learning on the marae, learning from aunties and gaining everyday leadership experiences.

> *Because my nannies, my mum, my aunties, they've all set a level of expectation in us and me of what service looks like. And so, for those experiences it's not one that's ever been self-serving, probably more of a hoha, it's been one that's quite sacrificial. So I've carried that wherever I've gone. The examples, the living breathing example of manaaki, of aroha, of whakamana have never been far from my upbringing. And that's a real privilege and a real blessing. – T.U*

This was supported by J.K, who made the link between leadership activities and learning in everyday life, and the clinical leadership that is required within Crown health organisations. She inferred that these skills are highly transferrable. T.B agreed, talking about his leadership experiences in sports and at home that he brings into the clinical environment.

What I found is, Māori do a lot of leadership things naturally in their normal lives that they don't actually realise are valuable and leadership roles just because they don't hold that title. As a manager or whatever in their workplace doesn't mean they don't naturally do it every day when they I don't know in their kapa haka life or when they're working at the marae and they're running the kitchen and all this sort of stuff. So they're natural leaders anyway and they, they just need to believe in themselves, in their work life I guess. - J.K

T.U spoke early on in our kōrero about the idea of service as something that was important to him, and returned to this again, linking it to his culture and upbringing.

I think the notion of leadership from a Māori (view), from my Māori one and from my Samoan one is very much founded in service. And very much founded in that sort of whakaiti or that humility that comes with knowing that okay, my best way to lead is to pick up a tea towel. – T.U

A.P painted a picture of the need to be able to multi-task in her acute nursing practice, not only to complete tasks, but to use the time taken up by things like medication and observations to connect with patients. She described this as something that naturally developed through experiences in her upbringing and as a skill that transferred into her working life.

… but it is it's just a learned skill of, a lot of the time, lot of things with my communication is it's just how I communicated with my family is you stand around the kitchen and you have a yarn when you're doing stuff and you, when you're on the marae peeling potatos you're talking to everyone at the table, you're not slowing down because someone asked you a question. You're still doing stuff while you're talking and you're involved in the whole conversation while your hands are busy and you just get really good at it – A.P

A.P expanded on her kōrero to include activity that does not necessarily have to take place on the marae, such as the multi-tasking that is required in cooking dinner and supervising tamariki. She referred to these learning experiences as natural, and a natural part of everyday life. This quote reflects A.P's whakaaro that many of the roles wāhine play in a whānau might lead them to nursing, such as parenting or looking after whānau who are unwell.

But it is it's a skill that you bring in with you and it's all the life things you bring in with you and that's what makes you a natural leader anyway it's for a lot of us we've had to step up very quickly in our own whānau so coming into nursing or into any healthcare profession allied, doctors or even our food service, they're still leaders. Everyone is in their own right. – A.P

N.T spoke about practicing leadership in safe environments, like the marae spaces where she grew up. She identified these Indigenous places as a foundation to step into “mainstream”.

> *They’re all Māori spaces and these are the stepping stones that we take and we love them because they’re safe spaces. So we need to nurture these spaces for Māori because this is where we grow our leaders. And then what will happen after a point in time is that you’re so confident in those leadership skills that you’ve nurtured and developed in these safe spaces that we then start to sit on, mainstream. – N.T*

T.U touched on safety in a slightly different way, indicating that Māori clinical leaders need to be safe in the places that they are expected to lead in. He inferred that not all Māori leaders need to take on the role of lion.

> *We should be cautious, not only as a system but as Māori, who we are putting up to represent us because like I said before, sometimes we need a lion but other times we need a lamb. But we can’t have a lamb sitting around a group of lions. – T.U*

As the quote above about lions and lambs suggests, leadership for Māori has different faces and can look different. Participants identified that for Māori each aspect of leadership is as important as another. These include obvious roles that require a leader to be in front and standing up, and those roles that tautoko and enable.

> *On the marae, leadership for wāhine looks like the kaikaranga. And leadership looks like when the, when you’re getting up to do a whaikōrero oh what’s the song? You know, there’s at least three aunties, who hold those leadership positions that have 20 songs up their sleeves for waiata tautoko! And you’ll whaikōrero you know that is leadership for everyone. We see, we can listen to their stories and how they weave everything together and, and how they find a hononga between the manuhiri and themselves and the kaupapa of the day. Leadership looks like navigating, tense situations where perhaps there’s something going on with the manuhiri coming on. Or there’s something going on within a whānau you know. Recently we have a tangi for my cousin who committed suicide and so, getting up and navigating your whaikōrero and encompassing such a heavy topic, you know being able to navigate that in itself is leadership. – N.T*

At a different point in the weaving of her pūrākau N.T returned to the idea that leadership manifests itself in different ways.

> *Someone might be a leader you know, an example the aunties that sit and cook in the kitchen, like they might not have the reo to do the karanga and the waiata but there they are*

in the kitchen every single hui, every single tangi they're there. So it demonstrates to us that there's many forms of leadership that there's not just one single form. You always know the one kuia who, who doesn't say much. But when there's something important to say, when they speak everyone listens. - N.T

In this instance, rather than only describing the variety of roles leaders can hold, she also begins to describe diversity in leadership attributes, listing quiet and outspoken as different ways to lead. The image that she creates of the Kuia who commands the room when she speaks is a powerful one.

I think in an indigenous (way), my Indigenous worldview, leadership is nothing to do with your title. Whilst I might of had a title that may have positioned me to some people's perspective, as a leader or as the leader in allied health in that context. Anyone who's been to a marae before knows that leaders come in all shapes and sizes and each role is as important as the next. – T.U

The only occasion of potential contradiction on the idea of culture shaping the foundations that we lead from is highlighted in this excerpt from T.B, who describes whakapapa Māori as the constant foundation, with culture as a more fluid notion.

Culture is dynamic, you have different friend groups throughout your years of life, back in the day they're dancing with you, you like dancing… now you love hockey. Later on it might be bowls or something… as you go through your time your priorities change and the culture of who you are as a person changes, but not your whakapapa right? – T.B

I have highlighted this as only a potential contradiction to this theme rather than a disagreement, because it seems likely that both interpretations are correct. Although whakapapa is a constant, the whakaaro from leaders who spoke about not feeling Māori enough sometimes, suggests that the power of our whakapapa is boosted by experiences of culture in the way that T.B is suggesting.

Authenticity

This sub-theme is about Māori leaders needing to be true to themselves, and the strength to be authentic that comes from whakapapa Māori and being unreservedly who they are. Participants discussed their whakapapa Māori as a constant, and a foundation. T.B and T.U highlighted this, discussing different aspects of their respective careers and their lives, with whakapapa Māori always being there.

Your priorities change and the culture of who you are as a person changes but, not your whakapapa right? You're still Māori and that's it. – T.B

Yeah, for me aye I guess it doesn't matter if we've been out one year and we're the new grad or if we're the head honcho, we're Māori aye? That's a title we can't take off or we can't change. – T.U

O.D spoke about the pride that she felt in being Māori and how she tried to role-model this in her workplace for her Māori colleagues.

Being proud and being Māori and that we offer a difference, because we do. – O.D

W.A reflected on her perception of strong Māori clinical leadership. She articulated that her perception of their strength came from the confidence that they portrayed and admired their ability to be their authentic self and being yourself without apology.

W.A: two of the other people were clinical, but I felt like even though I was in a leadership position I felt like they were stronger leaders than me.

T.M: What made them stronger leaders? Or what made you think they were stronger leaders?

W.A: I think just their mana, their presence. And their, assurance, I guess in themselves, in their space. They were just, unapologetically Māori you know. And I don't think I'm at that level yet you know?! I feel like I'm Māori but I'm apologising for it.

T.U described coming to a decision about being his authentic self from reflections on how others were leading, and how he didn't want to act. He combined this with the humility that he has from his upbringing which resulted in him choosing to lead with a gentler approach. Implicit in this kōrero was his temptation to judge his own effectiveness as a leader and critique himself based on the actions of other leaders around him. In this case, other leaders that T.U had observed were harsh and quick to anger.

What I came to, what I recognised, what I realised was that that's who I am. Like, that's me and that's that ability to lead authentically. No one's ever going to believe me or take me seriously if I'm rocking in there, putting people on blast, telling people… blaming, gaming and all this sort of stuff because that's just not who I am. And so I guess what really helped with me was being comfortable, finding… how I work best. This is how I want to work. - T.U

For J.K authenticity was about how she brought her own 'vibe' to the role, which included being Māori. In a similar manner to T.U this wasn't about doing what others had done before her, but was about finding her own path.

I feel like I've fitted into the role really well and was able to bring more of a Māori, well, not more of a Māori vibe but my own vibe which of course includes Māori culture because I am Māori. So I got, I get along well with a lot of the staff, especially the Māori staff. I make my decisions based on my own thought processes not what the others have just always done. Because my belief is just because it's always been done like that doesn't mean it's the only way or the right way to do something. And so I make my decisions differently to the other, the previous managers in that role, and it can be things like whānau members staying or how we deal with the death of a patient. – J.K

N.K and T.U both shared thoughts about being their authentic selves as Māori. They described being Māori as a benefit and something positive. N.K described the high numbers of Māori presenting to hospital and the positive impact it has when they have Māori clinicians looking after them.

Especially here… with our high population of Māori and with our high deprivation and so forth and the presentations that come to into hospital and so forth I believe it has been a positive that I am Māori. – N.K

T.U spoke more generally about the positive leadership he was able to witness through the wāhine toa in his whānau. He linked this positive role modelling to the way he wanted to lead.

I often think about the women in my whānau. They've always led the way and so when I think about being Māori, I think about them and so my experience of being Māori is very positive. I know what being Māori is to me and that's the type of Māori I want to share. - T.U

N.T beautifully captured the idea that being Māori doesn't require acting in a specific way. She had spoken about knowing she could be her authentic self at mahi, because it was valued by those around her. Her words 'just be you' speak to the strength of authenticity.

… and you'll get some who, like one's on her journey of rediscovering her language and she's enrolled in a Māori course, and she said… I'm going to be more Māori at work now! I'm like, you don't even have to say that you just be you. You are Māori. – N.T

As alluded to above, N.T experienced a feeling of being valued at work for her worldview, and described knowing that what she had to offer was valuable and worthwhile.

My work values me as a person but also my cultural heritage and my background they're starting to see how they can be of benefit in their service… thinking uniquely Māori as well like there's a big emphasis on, on the Māori staff in our service that, we our worldview is very important in that our opinions are, are heard and welcomed. – N.T

W.A spoke about authenticity in terms of being able to take action and do what feels tika and right. This included being able to recognise her own values and acting in a way that upheld them, regardless of what others expected of her.

> *I think it's actually about having the confidence in your values yourself and staying true to them that makes you become a leader. I think it's actually just ignoring those people and doing what is right and authentic to you. – W.A*

T.U talked about needing to find who he was, and the right approach to leadership for him based on being authentic and true to himself and what he had learnt from his whānau.

> *When we're thinking about leadership, I've always been of the view that there's an 'and-and', that there's a space for all of us, and so we don't need to stand on others to get to where we want to go. That's what I've held to. And that's what I know and, unapologetically and unashamedly, that's me, that's my style. – T.U*

This whakaaro from T.U touched on his belief that there is room for diversity in leadership. His description of 'and-and' reinforced that leadership can be reflected in different ways by people from different backgrounds.

An important aspect of authenticity for participants was being able to be their full self as opposed to being only a healthcare worker. This involved feeling able to bring the many facets of their personalities and home lives with them into the workplace.

> *I'm an artist, I'm a mum, I'm a really good cook, I'm all of these things and I happen to be a nurse, not I'm a nurse and I fit those things around it. And it's because of the things that I do outside of this place that make me good at what I do in this place. – A.P*

Throughout our kōrero A.P was creating a piece of art while she was sharing her pūrākau. She spoke about the influence that art and creativity had had on her life, throughout postgraduate studies and as a way to channel her energy.

> *People only see you, and your work colleagues only see you as this person as oh yeah, she's always here or you can rely on her, you can do that but they don't realise that you're actually juggling things at home to make this happen… there are a lot of background facets behind one person aye? … who is appearing there at work, who is presenting to be there to work… hospitals have tunnel vision. – N.K*

W.Y discussed the practicalities of having children and trying to work in shifts as though they don't exist. She talked about being strong enough now to put in boundaries and set expectations in her

workplace. This small act of self-care helped her to find her energy for mahi again, including the energy that is needed to provide good care for others.

> *I'm going to get my son to school first, [they suggested that] he can find his way or get someone else to get him there. I said no. No I can do this, this is only an hour. I said I can get my son to school, I'm happy and then I'll work. – W.Y*

Times where participants identified that they did not feel they could be their true selves were highlighted clearly by several of the Māori clinical leaders. W.A spoke about being encouraged in her clinical training to withhold information about herself, and the emphasis on maintaining professional boundaries with patients. T.U discussed the importance of being able to be yourself in a health environment in order to thrive, noting that thriving at work is not only about your professional expertise and identity.

> *… not sharing anything of yourself, keeping that part to yourself that was definitely we got taught. But I also remember learning and feedback from our clinical tutors over and over and over is about re directing people so that you can keep them on track with the information you're trying to find out and you know if they're going off on a tangent then you re-direct them and a lot of it being a student is about learning how to segue from one topic back to what you wanted to talk about but actually that's just completely at odds with, how you would be as a Māori person. - W.A*

> *… its sad right, to think that lots of us feel more like we're surviving than we're actually able to thrive and flourish as Māori. We might be performing top of our game as a physio, but if we're not our full self then we're never going to fully be thriving in my reckoning. – T.U*

T.B shared a well-meaning piece of advice that he received, that involved discussing his culture as though it was taking over his professional perspective. W.A shared something similar, where she felt she had to tone down her culture.

> *I had a discussion one time with another clinician. And they're like you know you're a Māori clinician, but remember, you know you're doing really well with your Māori side but remember you're a clinician too. If you're up in these situations, you want to be making sure that your clinical side I guess for use of a better word, is up there as well when you're at these kinds of levels of discussions. I found that quite interesting, thinking on that perspective. I was like actually, I'm Māori, I was born Māori, I've been Māori since the day I was born, that's what I am, that's who I am. I'm a clinician by trade, but I could have gone to and studied law, I could have studied commerce, I could have studied anything like you know*

kind of BA of whatever and that doesn't change that I'm Māori but it changes that I'm not a clinician right? – T.B

I'm Māori but I tone it down for this space! – W.A

W.A referenced the strain she felt following the bereavement of a close member of her whānau. She spoke about the need to keep up a professional façade despite the depth of her feeling, explaining that this was an expectation of a leadership role and that to openly show much emotion would be perceived as not coping.

I never cry at the hospital because I'm not allowed to, well not that I'm not allowed to, but I don't allow myself to here. Whereas it's quite normal just to cry and let the tears fall with Māori. But I would never ever do that, at work! I think Māori grieve better! And more openly, whereas if I did that normally at work, it would be seen as unprofessional or not coping. And then, yeah people think you're stressed, and you wouldn't be given leadership opportunities because, you can't cope with that at the moment. They would make that assumption on your behalf… I probably ah, have still always have a front here... I'm in a role here where it would be expected that I have my shit together. – W.A

A commonality across these leaders was the knowledge that being a whole person meant that they had to take care of themselves, as touched on with W.Y prioritising dropping her tamariki at school. R.D spoke about the need to look after her wairua at home to keep it strong in her hospital workplace.

Because I feel if you can't help yourself how can you help others? So if you're, like your wairua's strong, your mind is right. – R.D

I had to take care of me too and my family I had at home. How am I meant to take care of others if I can't take of me and my own whānau? So I just had to try and balance it, exercise came in good, meditation, far that was when I really was talking to Io!! – R.D

O.D performs different functions in her role with a specific number of hours allocated to one task or function and a specific number to another. Interestingly, she reflected on how important it was for her that she was able to whakawhiti these roles, weaving them together rather than attempting to split the patients she was seeing into separate needs addressed on separate days.

That was one of the hardest things I found when I came into this, is that people are in roles and specific whereas when you're in primary health, you're looking at the person collectively holistically, tapa wha is everything. So, to look at you know this is the baby that we're doing

for imms you're not looking at the mother or the contraception, sexual health whatever kind of thing. I just really struggled with that. – O.D

The way of working that O.D described in this extract is about including a patients whānau as an extension of them and illustrates a te ao Māori perspective of holistic care. Throughout O.D's pūrākau it was clear that being able to work in this way was an important part of her being authentic and true to herself.

Strengthening foundations

This subtheme recognises whakaaro from Māori clinical leaders about the importance of continuous improvement for everyone, both personally and professionally. It acknowledges that although Māori have ways of leading that emerge from learning on the marae and everyday life experiences, participants identified that they still need ongoing development to excel in leadership spaces in healthcare. This subtheme incorporates whakaaro on desirable learning and mandated learning, clinical training, post-graduate qualifications, mātauranga and learning such as te reo Māori.

A common topic across several of the pūrākau from Māori clinical leaders was experiences that they had in postgraduate study, which were both positive and negative. To achieve formal leadership titles some participants identified that postgraduate study was essential. N.K in particular spoke about her initial hesitation, but that she now encouraged other Māori to go ahead with study as a key way to advance their careers.

> *I've always encouraged my Māori, my Māori colleagues is, they'll go oh I can't be bothered nah, nah I'm just happy just doing this. And you can see that. You go oh have you thought of any postgrad papers because if you do this there might be other things that you could do. – N.K*

Although N.K discussed postgraduate study as a prerequisite for her role, indicating that it was not something that she enjoyed at the time and that it was a barrier for some Māori to advance, she went on to recognise that it was a positive move for her.

> *Now that I look back on it, I think it's, personally it was good. It's good because… it made you think differently, the papers that we did, the diagnostic reasoning was really good because it opened up a new understanding of the patient's conditions. – N.K*

In contrast, even after completing her Master's degree, A.P did not reflect on her experience positively, noting that the piece of paper was not something that she wanted.

It is a role requirement. I've been saying that whilst for the last 2 years I've complained through a thesis, because I did not do the thesis willingly. That it's a piece of paper and it's a role requirement, and not something that I actually want. – A.P

A.P continued her thoughts on why she completed the degree at all. She explained that aside from the role requirement, she completed her Master's qualification in order to be able to be more directive regarding further professional development. She felt that she would not have been granted funding towards learning in mātauranga unless she completed her formal study.

But, by meeting that I knew that I would have leverage to do the things that I wanted. I don't want to do anymore Pākehā papers… I want you to support me to do mātauranga which is going to help me in my role better… actually help me for changing systems. – A.P

R.D and O.D had both chosen not to pursue formal postgraduate study. O.D was further along in her career and acknowledged that this was a purposeful decision, while R.D spoke about plans for further qualifications at a later stage in her career. Both reflected that rather than a clinical focus, they would prefer recognition of training in mātauranga. R.D queried why papers specifically on a topic such as tikanga Māori were not recognised within the acute hospital environment. She points out that in fact, tikanga and clinical practice are intertwined for Māori, and that she gets called on in clinical environments to provide cultural expertise.

There's the cost. So if I was going to do postgrad, I would want to do it in like, Indigenous studies or something of the sort on the lines, tikanga Māori. If I was going to do it, it would definitely be like in Indigenous. I don't get why it's not clinical because that should be in all clinical things Māori. Well it is clinical, because when anything Māori comes up, I've got people running to me about it. – R.D

O.D spoke about the time and energy it takes to learn te reo Māori, but also how rewarding it was for her. She clearly identified te reo Māori studies as more important to her than postgraduate studies.

I never wanted to do postgrad papers. I've been doing my te reo, we've been learning through the wā and through EIT which is not recognised as postgrad papers. – O.D

There were suggestions from participants that lead to the conclusion that western ideas of leadership teaching and requirements need to be challenged. O.D suggested that tikanga and te reo Māori learning are important for anyone moving into leadership roles in health, not only Māori.

I think that doing the te reo Māori course was one of the most or even the tikanga was, I did tikanga through Te Wānanga as well. I think those things were beneficial, but I did them myself. I think those things should be for anyone that's going into any sort of leadership. – O.D

Four of the 12 participants had completed a kaupapa Māori leadership training, Ngā Manukura o Āpōpō (referred to as Ngā Manukura). This programme is specifically designed for Māori nurses and midwives, with a limited number of places offered for physiotherapists in 2023. They all spoke extremely highly of the programme, and in particular the potential they felt attending marae-based learning. A key concept within all of these whakaaro is by Māori, for Māori.

I believe in order to grow clinical leadership in Māori, it needs to be by Māori. Because Māori will, we have that experience to give, to lead from example. So it needs to be by Māori because the experience that we bring, the experience of relating as well. – N.K

I would really, really encourage you to do Ngā Manukura because it exposes you to so many other incredible people with incredible leadership from such a good variety of backgrounds. It just opens your mind and your thought patterns and that's what's so important. I think too because you stay on marae. And this is like all the learning that I've done through marae. It gives you that opportunity to be completely immersed in what you're doing for that weekend and that's pretty selfish almost. I really love that it's only for Māori. And I think that as Māori we need to be stronger with that. – O.D

I think there wasn't a lot of leadership training as a clinician, but also leadership training with a te ao Māori lens so recently, I have been doing the Ngā Manukura o Āpōpō which I think if I'd had that years ago would have been amazing. I think a lot of the leadership courses that I had leading up to that point or once I became a team leader were very much western centric and I think I only kind of, went through that because of the Pākehā side of me. I don't know if some of that would have been too, different I guess or, or not too different but just not as comfortable I guess for Māori. – W.A

J.K identified that she required management support to attend programmes such as Ngā Manukura o Āpōpō. She experienced difficulty not only in terms of support to attend, but also in identifying that the opportunity existed in the first place. She expressed frustration that the programme had been so well established but that she had not heard about it and those managing her had not suggested it.

> *That just really shows that these sorts of leadership programmes, need to be more. We need more of these. And when I've done it of course I was probably like the second or third person at our hospital who had done it. That's ridiculous. It's been going for like 10+ years like why did it take 13 years of my nursing before I even heard of it? Our hospital hadn't heard of it, and it was because of who was in our management prior. And now that we've got new management, it's finally came about - we've got this education thing on Facebook, and they put all these education opportunities on our education Facebook thing and that's how I saw it. Because we've got a few more Māori that are brave enough to move into these education roles, into these managers roles, into these leadership roles... then they're promoting it – J.K*

R.D also expressed frustration that she had never heard of Ngā Manukura o Āpōpō before our kōrero. Similarly to J.K, R.D concluded that this was likely due to her managers lack of exposure to Māori professional development opportunities, rather than deliberately withholding information.

Outside of Ngā Manukura o Āpōpō, A.P described the difficulties in current western training models, where the hospital structures that clinical leaders work within are not able to support people who are not academic.

> *It's hard because we haven't shifted from the western perspective of, this qualification means that you're qualified for this but actually the right person for the right role, doesn't necessarily mean they have to have that. It's, it's hard with this western model that isn't designed for those who aren't academic. – A.P*

T.U acknowledged the importance of taking the time to support and grow Māori into leadership roles in healthcare spaces where Māori are often required to take on leadership roles early in their careers.

> *There's so much change and so much thirst for Māori leaders. There's this saying right you've got to be quick but not be in a hurry. And so sometimes I feel like there's this hurry for Māori leaders and so people, our people are being appointed into roles that they haven't actually been supported or grown into, and then having to carry that load, usually by themselves. Or with their hand tied behind their back and with one eye patch on, makes it such a difficult task. – T.U*

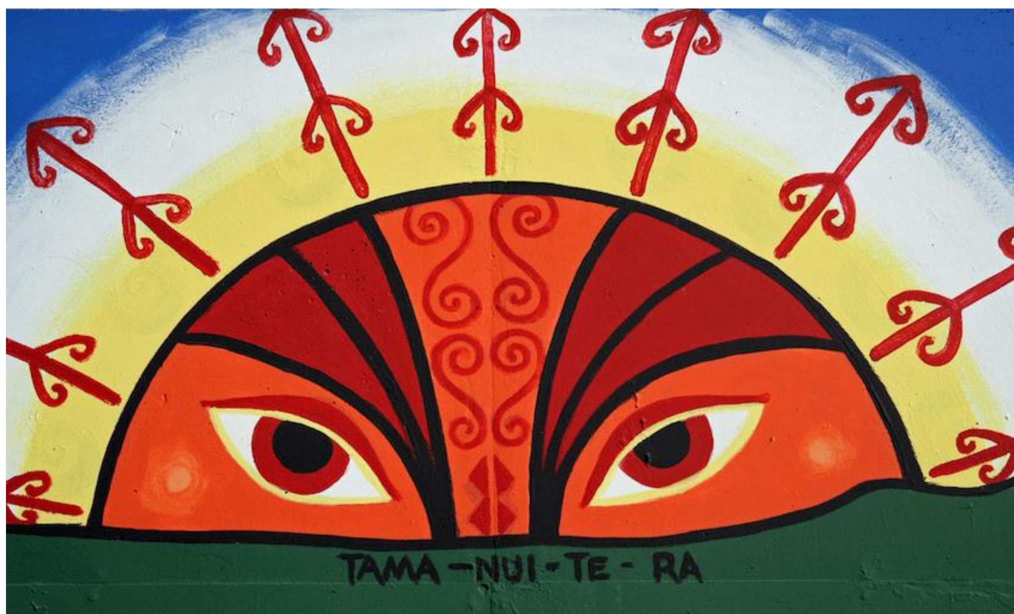
Rā

This section describes the theme of whakamana, generated from the rā aspect of the pūrākau framework. Awhi and tautoko was identified as a subtheme, recognising the support that is needed for Māori clinical leaders to grow into and develop in healthcare leadership. Rā has many

interpretations. These include the physical sun itself and the concepts of enlightenment, life and solar energy. Rā is also representative of Tamanuiterā, te rā who represents strength and the ability to bring warmth and light into the world. The concept of rā has connections to good health, where hau-o-rā, the breath of the sun can bring health and wellbeing.

Whakamana as a theme encapsulates descriptions from participants about being empowered and empowering others to shine. E whakamanahia ana e ngā kaiwhakahaere ki te whiti. This theme explores feelings of thriving, and the experiences of being mentored and encouraged by leaders, being shown opportunities, and offering that light to others. These findings build on the kōrero described earlier about authenticity, leading by 'picking up the tea towel', and Māori clinical leaders being there for everyone, not for themselves as individuals.

Figure 8: Tamanuiterā



This image of Tamanuiterā forms part of a mural in Timaru, artist unknown (Unknown) and appears in an online article in The Spinoff (Rangi., 2017).

Whakamana

Common across all participants' kōrero was an unwavering and altruistic desire to build up those around them regardless of professional roles they all held. The focus was clearly on fostering leadership qualities and cultural strength, with an emphasis on collaboration rather than hierarchical authority.

T.U beautifully described the concept of enabling Māori to shine through being able to freely demonstrate cultural abilities and strengths, without needing to hide away. He linked the expression of cultural self to thriving.

We can thrive. No matter what setting we're in we don't have to only be in a little corner somewhere and that's the only place we can thrive. We should be able to walk into any room and light that up. That's what we were meant to, that's what we're here for, that's who we are. And so I firmly believe that culture's our superpower and that enabling our cultures in our institutes, in our institutions will enable people to really shine. – T.U

In continuing his metaphor where Crown health organisations are represented by the boneyard, T.U identified that individuals should not feel confined to specific spaces but should be able to thrive wherever they go. Leaders who enable expression of culture in institutions will be enabling Māori clinical leaders to thrive.

T.B articulated his desire to create a ripple effect, where one person's change leads to another's and contributes to an entire cultural shift. His passion for influencing change through whakamana and enabling the growth of others shone through throughout his entire kōrero.

I think just, man if I could like inspire, one person to go out and learn the reo, go out on their reo journey, go learn. Then that person inspires one and then it's just a flow on effect. Then you've got people that are in the system. It's difficult to budge a system but, if you've got enough people in there that have that kind of whakaaro, that Māori whakaaro, that tikanga Māori then you're only going to benefit the equality and equity that comes out of that system. That was my big thing, I wanted to be able to inspire people to make their own journey. - T.B

T.B expressed powerfully that his desire for positive influence was driven from a desire to make his tūpuna proud, and that was what made him want to shine.

The big driver for me was just trying to show this amazing world that's out there, that people don't know about, because it's not taught anywhere unless you go out and discover it yourself and that's what I wanted to do. It just made me feel good like about myself and like you know I was doing my tūpuna proud. – T.B

Both of these kōrero have strong links with authenticity, described earlier as a subtheme of foundations for leadership. The ability of Māori clinical leaders to be authentic is supported by their environments and people around them and in turn impacts on their capability and capacity to inspire others.

When talking about her experiences at Ngā Manukura o Āpōpō, A.P reflected that the training did not so much try to teach a version of leadership, but to recognise the potential that all Māori have to be leaders.

You were just in this incredible space with incredible people who were coming in to share their knowledge. It didn't teach you how to be a good leader, didn't actually focus on that. It focused on how to empower yourself to empower others, or how to be a better version of you, to harness that so that you can emulate out change and encouragement for others and support and all those things… I loved it. – A.P

W.A spoke about her experiences as a leader and her battle for improving inequitable services, describing the inherent bias she came up against in others she worked with. In contrast to feelings of hopelessness evident earlier in her kōrero, she expressed a sense of satisfaction when she was able to get through to someone and make a change, even if it was incremental.

It's finding those moments, finding those moments where you can switch a light bulb on for other people is you know rewarding. – W.A

Whakamana for W.Y was expressed in her kōrero around the importance of teaching Māori to recognise their strengths and to embrace their particular leadership approach. She described knowledge that self-belief is teachable with enough encouragement.

I think teaching people to recognise their strengths and their strengths and their personality types and how they lead. Other people just need to believe in themselves that they can be a bit stronger and move up. Recognising those sorts of things so definitely that's teachable. – W.Y

N.K identified enjoying mentoring and teaching new graduate and early career health professionals in her roles. She reflected on the harshness of hospital environments for those who are still learning, and the importance of working together as opposed to working in a hierarchical way.

You don't talk to them in an authoritative way. It's talk to them in a more of a learning way. I'm here as your colleague who is learning with you, you know what I mean? So even if you just change those words, it doesn't feel so daunting on their learning. And the feedback needs to be constructive, it's not supposed to bring them down. - N.K

The lack of hierarchy in the approach of Māori clinical leaders was further reflected in the perspective of N.T. She described the difference that she had observed in western and Māori leadership, where leaders from a western perspective hold themselves separate from their team members.

I think if, if say you had your Pākehā hat on and you were in the clinical leadership team and providing advice to someone it would very much be, clinical leader here and staff here. And

you would be advising and there's definitely a difference in mana between those two people and what I find with Māori clinical leaders is it's about collaboration. I'm lucky because my role is, I'm the lead for the mentoring programme so as a clinician, my role has mentoring in it whereas like, why don't half our SMOs and our consultants have mentoring in their job description with time blocked off for it? – N.T

O.D expressed satisfaction in mentoring and teaching others. Interestingly, she included mentoring and advising her non-Māori manager as opposed to only those earlier in their careers. She identified encouraging others into leadership as important and shared a story about encouraging a former student to apply for a leadership position.

I think obviously because of my age I've gone over a number of years of leadership, and I think particularly for nursing one of the things that I don't think we encourage very well is leadership. I don't think we encourage people to look at it. – O.D

She reflected further on the lack of encouragement for leadership in nursing and the misconceptions around what qualifies as leadership, drawing on an experience of hesitation in applying for Ngā Manukura o Āpōpō.

I'd seen it, but I didn't go for it because I didn't think I was of that calibre. I didn't think I was, because it says it's for leaders and I would never think of myself as a leader, even though I was a leader. I was the nurse manager for, I don't know some, 15 years or something like that, but because it was a small place there was only 5 nurses or 6 nurses I just didn't think that's what they were meaning. I was thinking they were meaning you had to be a manager of a progressive, large organisation. – O.D

Although it did not arise frequently, two participants acknowledged that Māori are not perfect and are not always capable of whakamana. T.U described the impact that harsh environments can have on Māori. This resulted in leaders being quick to jump to a fight, hitting out at each other instead of building each other up.

What was most disheartening was I didn't see that often enough from within our own space, it's one thing if the Pākehā aren't doing it well, kei te pai, but if we're not doing it, if we're in some instances treating us like the Pākehā treat us then I'm like, bro what are we up to? I think a Māori approach to leadership has so many benefits for everyone, but I guess what I temper that with is we're all fruits of the soil and the winds and the tendering that we've had up until that point. – T.U

S.W was another who had unfortunately experienced working with Māori leaders who she felt did not naturally demonstrate mana enhancing behaviours.

> *Some people get into those positions that have absolutely none of that… they appear to be supporting their team but in the next breath they can be shitting on others… it's not kind, not thoughtful. – S.W*

Awhi and tautoko

Participants highlighted awhi and tautoko as crucial elements in fostering leadership, intrinsically linked to the concept of whakamana. Participants expressed specific ideas on the importance of mentorship and support from Māori. This subtheme also emphasises creating environments where Māori leaders feel valued and incorporates awhi from non-Māori allies who actively support Māori clinical leadership.

W.A identified tuakana - teina based mentoring as important for developing Māori clinical leaders. A key aspect of this description was a tuakana relationship that provide tautoko of both the clinical and cultural components. She reflected that although important, this holistic mentoring is difficult to find with clinical support often received separately to cultural support.

> *Having that tuakana teina model, where they can have someone who understands the cultural side and the te ao Māori worldview but also can help with the clinical side, because at the moment, you have to choose between clinical or cultural. I don't know that they're integrated. – W.A*

W.A articulated a dilemma in finding tuakana and supervisors in the current healthcare workforce. She identified that to progress to being able to support others, supervisors first must have survived the system. A sense of safety is highlighted in W.A's kōrero as important in the recruitment of students into hospital-based roles and the ongoing retention of kaimahi Māori.

> *I think being able to offer students a supervisor who makes them feel like they're in a safe space here, they're more likely to want to be employed here and then coming into those new graduated junior years having someone senior who can support that. Helps them stay I guess they're almost like a buffer, to help them stay but then those senior, clinicians need to have survived the system as well. – W.A*

Both R.D and W.Y identified a lack of available Māori mentors for themselves as Māori clinical leaders. R.D's kōrero captures her aspiration for someone to look up to who has had similar experiences and challenges to her.

To be honest, there's no one that I really know. I aspire to someone who made it from the bottom. No handouts no. None of that Māori privilege. Someone that made it from the bottom. Like, like that's what I inspire to so, I don't really, I don't know who I, the only Māori woman I really look up to is my nanny and, I think Nix is pretty cool!! Like her journey and how she's... I like to see people that have overcome things. They're the ones that really inspire me the ones that came from nothing. – R.D

For R.D, finding someone she identified as an inspirational leaders meant that she had to look outside of healthcare. Nix, identified in the kōrero above, is a wahine Māori influencer (@cwknix) who has documented her personal challenges and journey of addiction recovery on social media. This kōrero from R.D reinforces earlier statements about the importance of authenticity in Māori leadership. It is feasible that there are others who have worked with R.D who have similar backgrounds but chose not to disclose this in a similar way to W.A not expressing her grief in work environments.

Y.W echoed R.D's assertion that a Māori mentor in leadership is hard to find. She expressed frustration that finding someone to aspire to was difficult.

I think we've got that generation coming up, looking for that Māori leader. I think we've got to be careful. I have no role model Māori leaders, I haven't had any. I try and I try! …for me I've no role models I could look up to that are Māori. I've tried to look. – Y.W

A.P had a very clear role as mentor and tuakana herself, recognising like R.D how valuable it can be to have Māori leaders to look up to. This reinforces the whakaaro from R.D and Y.W of being able to see themselves in someone that they aspire to.

If you're being mentored and supported by someone who thinks like you, looks like you, does the things same as you or similar to you, you've got something to aspire to. – A. P

She spoke about her expectations for other Māori leaders to be taking on mentoring roles to grow the leadership workforce.

If you're a Māori nurse and you've got a Māori student in your area, you should be looking after that Māori student so that they know they've got an ally, that they know they can see themselves in that role. Because visibility is key, if you can't see yourself reflected in the people doing that role, why would you do it? – A.P

N.K described a situation in her mahi of identifying leadership potential in a younger colleague. In this scenario there were a lot of factors that had led to this colleague struggling, until she changed

roles, finding the working environment that she needed to thrive. N.K spoke about needing to provide additional awhi to those in this situation, or the system would continue to lose leaders with great potential.

> *It's almost like they're born leaders but even the ones that don't have the leadership qualities, even more so to awhi them along… We should be supporting, no matter what. Yeah. I just think that some people are missing a lot of empathy. – N.K*

N.T beautifully described the importance of tautoko and awhi in leadership. She recognised that for someone to lead, others need to tautoko that leader and uphold their mana by following them.

> *Because Māori inherently are, we, we are a people that leadership comes natural to. Leadership is everywhere for us and leadership doesn't just look like the person who's standing up leading, leadership is also, the rest of us having faith in that person. And, that is what Pākehā lack. If I'm being blunt. – N.T*

This acknowledgement of how essential tautoko is can apply to the numerous leadership roles on the marae. It highlights findings described earlier of the leadership role that the kaikōrero on the marae holds but recognises the importance of the support they receive from waiata tautoko and from the people holding the teatowels.

N.K linked her mentoring and support of others to nurturing a plant, advocating for an approach to leadership where those you are providing awhi to are empowered.

> *not to stamp on their mana you know? There's no stamping in growth because if you're going to stamp out not grow then you're killing. If you think of nurturing a plant. You're not going to stand on a plant are you? – N.K*

W.Y noted how important awhi is, expanding this to incorporate a team context.

> *I don't just look at myself, I look at my whole team. And I know my whole team… their weaknesses or strengths or even what makes them tick. And if I see someone struggling or asking for help, I put myself in that space with them. – W.Y*

With remarkable similarity N.K spoke about awhi for her whole team, recognising how much it is possible to achieve in a team rather than alone. Within this kōrero she also discussed the need to share accolades with a team as opposed to on an individual basis, noting that this did not always happen in western leadership structures.

> *I think about some of the managers I've had in the past, I've known that decision is more about you. It's been because you are trying to push your own authority… it hasn't been your*

idea, all you've done is signed it off. No, no no, this was a team effort… our team did this. We made it happen… because, what can you do by yourself? You're limited in your resources with just yourself. Whereas if you build your team up you can achieve more… build your team up to become leaders. – N.K

Another aspect of awhi and support was in not being alone if it was not necessary. N.T recognised the importance of having support in the form of other Māori, particularly in spaces where there was likelihood of whakaiti. As a leader, N.T was in a position to set up those around her to be at the table with others, rather than being alone.

And so what we've learned is that… when outside organisations come and ask if we could put forward an advisor from our association to sit on their organisation's board or advisory board, we say yeah that's fine but there's going to be three of them. Because there's no way we're sending one in there to sit and, and to be, I guess, whakaiti you know like, to be belittled in a space where we actually don't want to sit and we don't need to sit. I'm very unapologetic in these spaces when they want one person and we're going no. If you want, if you want us, you will have three. – N.T

Participants identified that awhi and tautoko can come from non-Māori leaders. This did not appear to be as important as mentorship from other Māori, however there were clear examples of non-Māori allies enabling clinical leadership. Examples of this included flexibility from managers, encouragement and potential to take responsibility for improvements for Māori.

N.T described the role that her non-Māori managers play in creating a supportive and enabling work environment. As described earlier in these findings, N.T recognised that this level of support is not common in all healthcare settings.

I think what makes it work here is we've got a combination of fantastic management that, that allow people to, to lead their own initiatives and to step back and to not micromanage, especially in the space of Māori and Pacifica. – N.T

N.K needed encouragement to embark on her journey to become a health professional, with that encouragement coming from someone who was non-Māori and a team leader in a service separate to where N.K was working.

… she was kind of always in the background all the time, she was that nagging person that said, look, I really think that you're wasting your time here being in admin, I think you need to go places. – N.K

N.K reflected that without this person believing in her, she would not be in the role that she has today. S.W had a very similar experience that influenced where she ended up working.

> *But I think that the other thing is when I was studying social work I was lucky that I was embraced by a Pākehā woman who was a senior social work supervisor and she really took me under her wing she knew that, well I did a placement, and I ended up working there so but only because she took me under her wing and helped me. – S.W*

N.T talked about the tautoko that non-Māori can provide, by vacating space for Māori.

> *The biggest one is, tangata te Tiriti vacating those spaces for Māori! We start to sit on, boards and associations and organisations that are non-Māori. And, we have a bit more confidence to have a voice in these spaces. And, to get into those spaces where we can actually have a probably a massive effect and, and we can effect change, we need non-Māori to step aside and allow Māori to take those spaces. – N.T*

T.U had an inspiring kōrero, imagining tautoko from the entire health system and the potential of an environment that provides awhi to thrive.

> *I believe that for us as Māori I believe that for anyone who isn't middle of the road, whether it's our rainbow whānau, our Pacific whānau our te mea, te mea, te mea if we can allow, enable, provide a system that supports the behaviour of thriving, then how can you not thrive?! -T.U*

W.A recognised that there were a number of non-Māori allies in her workplace, who had expressed a desire to improve services for the Māori patients accessing them. She discussed the role that non-Māori to take on some of the burden of teaching cultural safety and competence.

> *I should be approaching those people in terms of taking some of the cultural loading workload off Māori staff so that they can focus on engagement with our Māori clients, and we can use allies to teach basics to non-Māori. – W.A*

Another source of awhi for participants came from connection with other Māori. Connection was expressed as something that was vital for Māori clinical leaders, occurring in a variety of ways. Examples explored below include connecting through being Māori, through actions based in collective ways of working and through expression of values.

W.A identified early in her kōrero that connection was important for her as a Māori clinical leader. She articulated that as a clinician, she was able to get better outcomes for patients because of her

emphasis on connecting with them and their whānau. She reflected that this was just as important for her in leadership as it was in clinical practice.

> *In terms of leadership, I have always had the values of connecting with people and building those therapeutic relationships. I think that whanaungatanga has been something that has been a key part of my work both as a clinician but also in leadership. That's about relationships. – W.A*

T.U described his experience in facilitating connection for Māori across professional boundaries. He reflected on the significance of being Māori as a way to overcome differences in professional culture or practices. This connection helped to bring people together to create culturally safe spaces.

> *The positioning and the jostling for allied health professions, right? Pharmacy are saying this, psych you know, we're the most important, the physios are trying to be the pseudo doctors, but whenever I have a room of allied health Māori, we're able to cut that away so easily because we're Māori right, first and foremost, that's who we are and so that's what we're there for and so that is such a powerful connector in those spaces. – T.U*

T.U discussed being able to draw strength from connection. He acknowledged that although he may have frequently been alone in meetings or project spaces, he could stand tall knowing that there were others spread across the hospital with the same collective goals.

> *There's no one else in this meeting to do those things, but then also recognising too, well not recognising but more drawing strength and encouragement from my mates who we talked about that who are on the frontlines. And so, yeah really drawing kaha from them knowing that we're doing similar things but in different contexts so yeah. – T.U*

Participants expressed that te reo Māori is a powerful way of affirming their identity as Māori and connecting with others. The act of learning and using te reo Māori contributed to a sense of cultural belonging and pride. The journey of engaging with the language was presented as a step towards embracing one's Māori heritage. A.W reflected that perhaps if she had more reo, she might have felt like less of an imposter. O.D described te reo Māori as important in connecting with the communities that she served.

> *It has made me feel I'm Māori. Okay, I can only speak so much but that's you know that's more than what I did before. And that's why I'm going forward with it. - W.Y*

> *I keep thinking that I need to do more language courses because I feel like I would feel more, legitimate almost, if I had the language, if I could speak te reo. – W.A*

This is for me, for my whānau, for my mokopuna. And what you're asking for is actually, for my community but my community will, benefit from me doing this also. – O.D

Kau

This section describes the theme of grit and determination and the subthemes of creating ripples and bravery. Kau references ideas of being alone and of solidarity. It also has another angle of being able to move forward without hindrance. The theme of grit and determination reflects the true strength required of Māori clinical leaders. Many of the participants did not have straightforward paths into their careers and clinical leadership roles. For example, entering into tertiary study with young whānau or overcoming confronting social situations. These participants displayed amazing resilience in their ability to overcome barriers and succeed as they had. Conquering sometimes significant issues had a positive impact on the leadership of participants, leading to an ability for both fierceness and empathy.

The subtheme of creating ripples encompasses whakaaro about the ambition of Māori clinical leaders to drive change in their teams, services and in the outcomes for Māori patients. It builds on whakaaro about the impact that inspiring one person can have on a system as those ripples spread.

The final subtheme presented in this findings chapter is bravery. This subtheme reflects frequent inspirational descriptions from participants of being alone and of feeling distress, but of showing up to make change in spite of this.

Grit and determination

The first extracts from participants reflect tertiary study as an area where determination and an ability to battle through was clearly displayed. This study includes undergraduate and postgraduate education.

Within her kōrero, S.W described having her whānau when she was young. She spoke with pride about her pēpī, who are now grown, but reflected that having a family early made the decision to enter into tertiary study difficult. She, like other participants had to find training that did not require her to leave home for a large centre.

I always wanted to be a social worker and when I was oh you know younger and had my babies, I was lucky at the time to find out … were offering an introduction to social work and I thought aha that's my opportunity to see if this is what I really want to do you know and still care for my babies. – S.W

R.D articulated the resolve she needed to complete her degree, glossing over the significance of the social issues that she dealt with during her years of study. The sense of pride that is expressed in this kōrero is related to achievement in spite of challenges.

> *I wasn't even too sure if I was going to make it to the end to be honest with you. But I did, I had a 6-month break but because I had other social determinants to have to deal with on top of the study. I did it though. I didn't fail anything. I literally passed the whole thing through. But I had to manage other, other issues. Because I was on a benefit. I had three kids. – R.D*

N.K started her postgraduate qualifications while working at the same time and reflected on the difficulty of shift work and nearly full-time hours and study. The challenge for her came when her mokopuna moved in. She reflected on the achievement, acknowledging that she was not sure how she managed it but described a vast resilience.

> *We did postgrad… and I was blimen working .9, I was working .9 in ED like shift work, postgrad study and all of a sudden we were chucked this curve ball and we were bringing up our mokopuna… it's moments like that I really, that I realise oh my god how did I do it you know? – N.K*

In her leadership role A.P had noticed similarities amongst the people she was supporting through their nursing mahi, that echoed her own journey and that of R.D, S.W and N.K. These similarities centred around raising and supporting whānau.

> *Māori are more likely to go into study when they're older. They've already had tamariki, their kids are at school, so they're bringing in their Mum life skills into nursing and it's such a skill. Because that tiny little terror tries to kill themselves at least two times a day and you're really good at stopping it. - A.P*

Remarkably, when discussing elements of struggle and the hurdles they had overcome in their stories, participants all described this from a position of strength. They were undoubtably stronger from having overcome these things and had a confidence about them as a result. W.K was at the early stages of her bachelor's degree with a 9-week-old baby when her relationship broke up, having a huge impact on her life. Despite this, she continued on to complete her degree.

> *I'm now living on a mattress at my friend's house with a newborn and a 3-year-old. And now I have to go on a benefit, and I need to find myself my own house and all of this sort of stuff and how am I going to do this as a student? But you know I've had a rough life already so I was like nah fuck this, I can do it. So I just knuckled down and did it basically. – W.K*

A.P had the additional hurdle of being told by a teacher at high school that she wouldn't be successful. It was very empowering to hear the pride in her voice while she was recounting this story of achievement in spite of such negativity as a rangatahi.

> *I do like telling people now that I was told I was going to be nothing but a dole bludging statistic is what one of my teachers told me. (She) said I was going to be nothing but a dole bludging statistic who popped out babies when I was 15. And I turn 30 in 10 days and I've never been on the benefit I do have a child, she was incredibly planned. And yeah. I have a Master's degree so. – A.P*

Outside of a study environment but in a similar way to W.K, R.D was able to tap into her experiences and personal challenges as a source of determination. This determination allowed her to navigate a hospital environment where she had experienced bullying and to overcome this.

> *When I was first new graduate there, I felt a little bit bullied. But then I thought nah man you came from the hood. If you can handle the hood, you can handle anything. So I started standing up for myself… I thought, nah man, I'm not going to let this hospital take me out. – R.D*

R.D described being able to help rangatahi more effectively in her current role, because of the insights that life experiences such as growing up in a gang environment provided her. R.D and W.Y both discussed that their life skills and experiences were used in ward environment. In R.D's case it was to work with people who were challenging for others in the nursing team to manage. This reflects the importance of whanaungatanga in practice and the importance of a workforce who can relate to a diverse range of people.

> *… if a gang member come in obviously, I was the nurse for him. There were some situations that I didn't like. Aha! It ain't him, it's you fellas that's the problems because he's fine when I'm in here. And even he said he felt a little down with them and I said oh nah brother I'm here. – R.D*

Most participants described the important role that whānau had to play in helping them to succeed and get to where they are today. This included whānau looking after tamariki, assisting with day to day tasks like kai, and providing much needed encouragement to succeed.

> *I had friends, and I had some family and that. Yeah, that helped to actually get through and like my uncle and that he would like help look after the kids so I could do like my placements and all that jazz so it definitely played a part. - R.D*

I've had an awesome, awesome family support. When I did my training I was a single mother with my two children and my parents, Māori family just amazing. They just, you can get your aunty, your uncle you know they'll all just come and help you because they know where you want to go. – W.Y

As evidenced earlier by S.W, N.K found that being able to study in her hometown made all the difference to her ability to succeed. She was able to draw on support from whānau and friends while she was studying for things like looking after her tamariki and particularly at times when she was required to be on clinical placement.

I was able to study here and not move away from home, whereas nurses in the past have moved away from home. – N.K

Creating ripples

Participants identified their desire to influence change for Māori accessing healthcare as a source of their grit and determination. Creating a ripple effect by influencing one person at a time was identified as a powerful approach by T.B as described earlier in the findings chapter. Elements of this philosophy were present throughout other pūrākau in relation to gradual change, creating and growing influence simply by questioning processes. Participants described directly implementing changes themselves, noting that when others saw success in an approach, they were likely to try it themselves. Another element of this subtheme involves elements of two seemingly dichotomous ideas: the importance of Māori clinical leadership at all levels in the healthcare system and the power of clinical leaders to enact change in the clinical environment, regardless of job title.

W.Y voiced positively influencing her team through demonstrating action, enacting the adage of "be the solution, not the problem". She described role-modelling proactive problem solving in order to encourage others around her to do the same.

Don't just keep moaning about it and moaning about it and moaning about it. I'm one that's - so what do you want us to do? What's the solution? Let's try and figure it out together. - W.Y

A.P identified that there is a need for Māori leadership at all levels of the traditional hierarchical structures of a western health system. She expressed that she felt large institutions such as hospitals did not value its clinicians as much as those with designated leadership titles. She noted that many Māori kaimahi were disempowered because they did not have a job title.

… while we need people to stay at the bedside we also need people at leadership roles to make changes because unfortunately we do work in a Western society that values titles over skill. – A.P

W.Y shared kōrero around feeling the difference between leadership with a title, and on-the-ground leadership.

I don't do it for the title, I have always been told, right from even corporate is that you will make a good leader, you will make a good manager. But I've always said, I'm not chasing the title. There are all sorts of leaders. I do feel that I'm a leader in mentoring and supporting and that's fine. It's not a money thing, it's not a title thing. I want to see people grow and develop. – W.Y

Evident within this kōrero, where she had declined a management pathway in favour of being able to provide mentoring and teaching for nursing colleagues, is the difference between a manager/title and a hands-on leader. In amongst the whakaaro around needing leaders at all levels, is the suggestion that Māori clinical leaders feel a pressure to move into formal leadership roles in order to affect change. This is illustrated further by R.D. Similarly to Y.W, R.D had declined opportunities to pursue movement into a formalised leadership space in order to stay closer to her community and the people she wanted to help.

I have been offered a job, this lady come in to see us one time and offered me a job at... it paid more, I just didn't apply for it. I do enjoy my job, what I do, and I want to tell people things that I didn't know. Things I wished someone had told me. - R.D

At the time of her kōrero, N.K was in a titled leadership role within her service. She articulated her decision to apply for this position to have more decision-making power to make change. This decision reflects the perspective of A.P that gaining titles in a hierarchical structure is important. N.K however made a point of highlighting that this was for the benefit of Māori kaimahi, as well as for Māori patients rather than for herself as an individual.

… it was never my intention to be that [manager] because I want to rule. It was my intention to get into leadership roles to make some changes. To create change… to make changes to pave the way for others. – N.K

W.K had similar thoughts to N.K and A.P, expressing the opinion that to make a difference and a better life for Māori, more Māori needed to take up leadership roles.

I think the biggest thing for me and for future Māori leaders is, self-belief. Believing in themselves and that their people actually need them to become leaders. And for us to make any real change for our people, we actually need to be doing that from the top we can't do that from the bottom. And yeah we need to believe in ourselves and if more Māori are coming into these leadership roles and doing what we're doing, we have to bring up our people. We have to be the ones to lead them in that direction. And show them that this is how we make a better life for our people. – W.K

In contrast to the perspectives of needing high level leadership, W.Y identified that her strengths lay in problem solving for Māori in clinical spaces. She identified the effect of creating ripples over time, noting that making changes patient by patient had led to a gradual shift in what was accepted by management. This is a perspective that reinforces the potential power of clinical leadership.

Just making that change aye? Something a bit different and not so rigid and that's probably one of my, one of my strengths is thinking outside the box. – W.Y

A.P and W.A also noted that strength and potential power that Māori have to create change on the ground, in clinical spaces.

Māori are really good at advocating for patients, making changes, making waves in their areas and standing up for everyone, especially for Māori and Pacific patients… working in projects with people there's always Māori nurses involved in wound care, diabetes, the urinary resource nurses who are just amazing clinical nurses who work on the floor. Who aren't in senior roles, they do leadership things in their areas and they do them really well… you don't have to be in a leadership position to make changes - A.P

I think it's those people on the ground, where it makes the biggest difference as well, infiltrating the teams I guess. – W.A

At a different point in her kōrero W.A mentioned the positive influence that clinical leaders can have to create ripples of change. She spoke about the outcomes that Māori clinical leaders can achieve for their Māori patients by making connections, establishing strong relationships and empowering patients.

I think they're naturally doing it, Māori clinical leaders. I think they work in a way and people see the outcomes they get, so other people start picking up on that and role modelling and imitating it. – W.A

T.B shared a story about the importance of empowering patients through shared knowledge, and the ripple effect that this can have through a whānau and not only for the person sitting in front of him.

> *What we need to do as health practitioners is view it as a blessing that they're coming in to see us and that we're not above them. We're together and working together towards that persons hauora. Knowledge is power. They don't have that knowledge that we're blessed to have and to have learnt, so, if we gift them that knowledge as we should, they have that ability to gift that knowledge to their tamariki, their mokopuna, their mokopuna tuarua and their health and hauora exponentially increases. – T.B*

Given the context already established that these Māori clinical leaders work within, in many cases the kōrero naturally turned what drew them to the leadership roles that they're in and why they do what they do. For a lot of participants making positive change for Māori accessing healthcare was a strong driver, despite the barriers they faced.

> *So I took those roles on because it had such an equity focus and Māori Pasifika which was my passion. – O.D*

T.U spoke very specifically of the health of the whānau in his community, and of wanting to do more to improve the healthcare services they receive. Within his words was the impression that health services seek improvement as a paper-based exercise, whereas he clearly felt the real-life impacts of inequity and racism for people who were important to him.

> *… was where my family lived, that's where my whānau go if we're sick. And so I was quite adamant that it wasn't just about the quantity I also wanted quality and so wanted people who had the same, had similar aspirations for their community and so it wasn't just about, can you tick a box, it was actually about the service sort of component. I felt a real heightened sense of wanting to do more. – T.U*

T.U went on to talk about the weight of knowledge and awareness of just how bad the health inequities for Māori are. This had an impact on him, emphasising the need to grow kaimahi Māori numbers and continue to make improvements.

> *It really opened my eyes, moving into Māori health really opened my eyes, it's hard, you can't unsee aye once you've seen. These are things that we all experience as Māori but once you start seeing the data and the evidence and all of the stuff, that just fuelled my, oh yeah cool, this is somewhere that man we need more of us in these spaces. – T.U*

W.Y responded to a query asking if it can feel like a burden sometimes, being a leader to improve things for Māori? While she disagreed that it was a burden, she did express feelings of exhaustion, and acknowledgement of needing to share the load with others.

> *I don't think it's a burden. It can be if it's day in day out, day in day out kind of thing you know, exhausting. But I feel, if I'm the best person for them, I'm going to put myself forward.*
>
> *… just share it, just share the burden and don't get exhausted, switch out, switch out, I do that a lot with our team. They've taken on families and I've said do you need a break? Switch out. Yeah. Look after yourselves… The system we only have so much to play with you know. - W.Y*

As touched on earlier, R.D spoke of needing to manage her self-care carefully, especially while working within an unfriendly hospital environment, with N.K also admitted to feelings of exhaustion within her kōrero.

> *I just felt that I was going to burnout... if I wasn't already. It does get tiring because you think, well, what a load of... all these values that we had before Te Whatu Ora... those are only just words because they've never meant anything. - N.K*

N.K herself had made the move into a formal role and discussed the challenges of being true to herself and acting authentically as opposed to acting in a way that she had observed non-Māori leaders to act. Once in the role, she needed to find her own voice and continue to advocate for Māori in her communities.

> *It is confronting... a nagging reminder that you're forever having to make changes, not only in your own practice, but also to make changes in your work environment... to confront the way people think. The more I went into management, the more I felt that I hadn't been addressing some stuff... Just because I climbed the ladder doesn't mean to say I, I mean I was supposed to climb the ladder to make improvements for my people, not to be suppressed more... why am I forever having to justify things, when, at the end of the day aren't we here for the patient? - N.K*

In addition to her passion for making improvements for Māori accessing healthcare, W.K spoke about her desire to make experiences within hospitals better for new graduate Māori nurses. She expressed hope that adequate support would influence them to stay in the hospital environment.

> *When I first started at the hospital and especially in ED there probably was only maybe two other Māori nurses there. And I believe my, preceptors who I had didn't, do it justice they*

> *didn't give me everything, didn't give me enough in the way of preceptorship and support. And because of that I have always wanted to be better for other student nurses. – W.K*

Connection, relationships and collaboration were identified as both a way to create change and as a reason to stay in leadership roles. T.U spoke about how important relationships were, when his role didn't afford him resources like big budgets or staff. These relationships were an essential tool in his ability to create change.

> *That's all we had, was our ability to influence, because we sat within a Māori team because my role sat within a Māori team it didn't have direct report or direct influence over any of the allied health teams as such. It became, very important to have strong relationships with the decision makers to be able to wield a level of influence that resulted in some sort of positive change. – U.T*

O.D reflected on connection and relationships in a different way. She told a story about driving out to a local marae with one of her kaiāwhina colleagues who had whakapapa to the hapū. They wanted to be able to support the hapū with delivery health services in their community. She described the power of feeling connected and a sense of achievement from the relationships rather than the work they were there to do.

> *…we're trying to develop a relationship with this particular group, the kaiāwhina, they are her relations and the nannies were all so pleased to see her. And we had a really good couple of hours out there and we did some really good relationship building, rebuilding and we got in the car and drove off, and I was like oh don't you just love days like this? And she's like oh god I feel so, re-filled I love it. This is what we're doing, this is why we do it. – O.D*

Bravery

None of the participants described themselves as brave, however what was clear during kōrero and subsequent analysis was that these clinical leaders were often on their own on project groups, on clinical wards and in meetings; but that they continued to show up anyway to influence change. Bravery and determination seemed to go hand in hand, with change being a reason to exhibit bravery and show up even when there was no one else. Rather than using the following examples as further confirmation of the colonial and difficult spaces that Māori work within, under a Kaupapa Māori lens each of these excerpts has been chosen to demonstrate the day-to-day bravery of clinical leaders in continually striving for change.

I think that recognition that leaders is predicated on action rather than title. What was very evident and when I think about my mates and I think about them and their leadership capability it's the fact that they're there, and often they're the only one there. – T.U

This was supported in other kōrero, and is illustrated in this excerpt from A.P's pūrākau.

A leader in Māori is someone who's willing to go battle for you and stand up for you. – A.P

In different points of W.A's kōrero, she expressed worry that she wasn't doing the right thing. In this example, the concern is specifically that she did not have close contact with local iwi, and an awareness that the input that she was providing to improve equity in service delivery did not provide an iwi perspective.

But sometimes I'm the only voice at the table, so I question whether a little small Māori voice is better than no Māori voice. Or you know, some Māori voice without local context is better than nothing but then it's also about trying to draw those other people in and connecting with the right people. - W.A

At a different point in her kōrero, W.A referenced again the fact that there are very few Māori leaders working with her. She reflected on her career pathway, and similar to the whakaaro above from W.Y is the mention of carrying a cultural load, all the more heavy without someone standing behind her.

I think in what was DHB and now Te Whatu Ora because you might be one, the Māori in your service or one of two in a group of 50. I think I was the only Māori physio here for, maybe the first 7 or 8 years and now there's another one or two. When I'm only beginning on that journey as well it was quite a lot of pressure to carry, that expectation for the service and to carry that cultural load when I didn't feel like I was there myself. So, having to teach others, or advocate for systems to be more equitable or to have less systematic and institutional racism, it was hard because there was no one there to tautoko what you were trying to do. – W.A

This was echoed by other participants. What appeared to be key about all of these examples is the determination that these leaders showed.

I'm the only Māori down there at the clinic. It's so difficult to find Māori. We're very thin down here. I'd love to see another Māori nurse down here to be honest with you, I'd give her a high five. I've got my friend but she isn't working as a nurse at the moment. She's the only other Māori nurse. – R.D

I'm the only Māori social worker here in this hospital. - S.W

When I first started at the hospital and especially in ED there probably was only maybe two other Māori nurses there. – J.K

T.B spoke about not only being out-numbered, but also about being out-numbered by the people who designed the system.

Generally speaking most of the governance spaces are predominantly the people that wrote the system as well and so you're trying to navigate those kind of conversations with those people. – T.B

A.P talked about being headhunted, because there are so few Māori nurses. She was able to use this uniqueness as a benefit to her career.

I got head hunted for a job in another ward without even applying they were like hey we really want you, do you want to come and work for us and I said no but I used it as leverage to get, faster in my ward. And that's because there was no other Māori nurse. - A.P

A.T was not only the only Māori person working in her area, but described being the only one who could uphold tikanga in their day to day work.

If you're in a space where you're the only Māori person in that role like we've already addressed, the only person in the waka that's paddling and it can be very fatiguing so you know I do the interviews but I'm the only person who can do a karakia in our department. And you know it's a lonely spot to be in, if there's nobody else that's willing to embrace and try and learn. - A.T

Although these whakaaro from Māori clinical leaders are describing incredibly difficult aspects of their everyday work, there is an inherent bravery and courage that can be seen throughout the different kōrero.

Kupu Whakatepe

This chapter has presented key themes in the voices of Māori clinical leaders under the guidance of a pūrākau framework. The first theme identified was foundations for leadership. This explored the whaakaro of participants about the ways that culture influences leadership, creating a foundation and describing ways of acting. Subthemes were authenticity and strengthening foundations, where the importance of Māori clinical leaders being their full selves was explored along with descriptions of how these leaders strengthened their foundations.

The second theme identified under Rā was whakamana, with subthemes of awhi and tautoko. This theme expressed the concept of whakamana, mai and atu, both from the Māori clinical leaders to others, and received by them. This was identified as an important concept in many of the pūrākau, aligned closely with receiving support and mentoring.

The final theme articulated in this chapter is grit and determination. It described the strengths that Māori clinical leaders have in the face of sometimes overwhelming obstacles, including the strength that is developed when obstacles are overcome. The subtheme of creating ripples speaks to the drive of Māori clinical leaders to create change, while bravery captures the strength of the Māori clinical leader who shows up to act in spite of being the only one at times.

In presenting these findings I have applied a Kaupapa Māori lens to extrapolate information about the racism that Māori clinical leaders experience and the colonial environments they work in. This has met the aim of allowing themes to focus on elevating the knowledge that Māori clinical leaders have shared. The discussion chapter will weave these findings together with literature to provide recommendations for change.

DISCUSSION

This chapter will weave together the pūrākau of Māori clinical leaders and key information about the system that they work in to add to the existing mātauranga about Māori leadership in health. Key pou that will be discussed are collective pūrākau, the power of the clinical context, e whakapai ake ana, and whakatika.

As highlighted early in the findings chapter, the voices of Māori clinical leaders are vital to this research. Therefore, I have chosen to incorporate direct quotations in the discussion where this helps to illustrate an idea. These quotes have all been introduced in the findings chapter, to avoid introducing new information from participants.

Within this research, racism and negative experiences have been well established in both the literature and in the experiences of participants, therefore this discussion aims to walk the delicate balance of focusing on what Māori leaders need to thrive without dismissing the environments they live and work in.

Revisiting the research question

The overarching question that this research has set out to address, is "how should Māori clinical leaders be supported to thrive in Crown health organisations in Aotearoa?". This research aimed to bring about transformative change through in depth understanding of the current context, articulation of the full scope of Māori clinical leadership work and provision of recommendations for improvement based on the pūrākau of Māori clinical leaders.

The concept of thriving is a key component of the research question. It was defined early in this thesis as a psychological state where a sense of vitality and ability to learn at work were essential (Spreitzer et al., 2005). A number of factors key to a thriving health workforce have been identified in literature. In research specific to Māori and Pacific allied health practitioners thriving in their first two years of practice Aotearoa key factors included opportunities for cultural development, valuing cultural intelligence and culturally safe and enriching environments (Tofi, 2022). Factors identified by research abroad were self-awareness, insight into potential and thriving as a collective (Lyman et al., 2023; Zhai et al., 2023). Each section within this discussion chapter aims to build a full picture of what Māori clinical leaders need to thrive in Crown health organisations to add to existing mātauranga about Māori leadership in health. Where needed, suggestions are made on how Māori clinical leaders can thrive, and what factors can positively impact on their thriving.

A Collective Pūrākau

Prior to moving further into this discussion, I want to share a story that goes some way to articulating the full scope of Māori clinical leadership practice. This pūrākau illuminates different and

sometimes competing aspects of clinical leadership, which emerged from the perspective of the participants as a collective. In this research, pūrākau have been used both as a kaupapa Māori foundation from which to gather information and as a framework to guide uncovering meaning in the stories of Māori clinical leader participants working in Crown health organisations. Capturing the full scope of Māori clinical leadership with any one story or perspective is limiting. Thus, in this story, elements of pūrākau from Māori clinical leaders representing a number of different professions, perspectives and experiences are woven together to contribute to a collective understanding, with evidence from individual pūrākau in brackets.

> *A Māori clinical leader inspires regardless of their job description and title, rather than because of it (nurse, physio, doctor, social worker, manager, director, friend, aunty, cousin). They are fiercely strong, challenging and difficult, while standing to protect those who are vulnerable (the new grad nurse crying in the toilets and the gang member patient who self-discharges). They feel every arrow and barb but roll with those blows so the people coming up behind them don't have to feel the full impact (protect the teina, so they can become the tuakana). They carry unseen scars from the battles to get to even ground, which, rather than weakening them make them even stronger and determined and formidable. They are not infallible, and have insecurities inflicted by colonisation and racism (write me a policy before you can use rongoā here, treat this Māori person, say karakia, cultural learning happens on your own time). A Māori clinical leader knows that protecting and nurturing wairua looks different for every person and can generate the time that wairua needs (talking to Io, connection, creating ripples, speaking the reo, making a difference, hop to it then!). Whānau are both the reason they're standing on the firing line, and the footing that Māori clinical leaders need to be able to stand with strength. They get praised for navigating two worlds and get told what a skill it is, changing and blending themselves to work in (a.k.a. infiltrate) a foreign space. They make the foreign space (racism for days!) less foreign with manaaki and reo and mauri. Being a values-based leader is a good thing, it's even better if the managers they work under are values-based, lets change them too (you're not going to another tangi? Yes. She is). Being a servant leader is a good thing, it's even better because Māori clinical leaders know exactly who they're there to serve. They get asked to sit at the board table (on their own), with the people who created the board table, who want the mana without the challenge (nah, you can't have one of us, have three instead!). They get asked to be on the project group (we've created this thing, brown it up please), and they do it, because it's a ripple that <u>will</u> spread outwards until it covers the whole lake. They lead at the marae, on the cricket field and the netball courts, at kapa haka and in ICU. They lead in allied health, in*

nursing, in medicine, in workforce development. In acute care, in community, in discharge planning, in discharge rescuing. They understand the worth of quiet strength from behind (with the tea towel, at the patient's bedside, tautoko). They know the worth of being loud from the front (which is best today, the lion or the lamb?). There are lots of ways to be loud for change. There are lots of ways to lead, and Māori clinical leaders do all of it.

The value of this collective pūrākau is not only in acknowledgment of the difficulties that Māori clinical leaders face in their everyday practice, but also in acknowledging the sense of strength and complexity of experience that it portrays. This complexity is clear in a continuum across which the Māori clinical leaders practice, with frequent references of autonomy and empowered practice at one end, and restriction of self and survival at the other. For example, R.D displayed an innate toughness that originated from extremely difficult social circumstances, however she also vividly describes taking care of a young migrant nurse. A.P referenced everyday difficulties of 'racism for days' however appeared to find great satisfaction in finding work arounds in the system.

Linking Māori workforce and Māori leadership literature

The scope of my literature review, as presented earlier in this thesis, was focused on literature that specifically addressed Māori leadership in health. With this focus, I excluded literature that recommended Māori leadership as a solution to a problem or literature that does not purposefully explore elements of Māori leadership. I noted a paucity of literature related to Māori clinical leadership. The similarities in the pūrākau shared by Māori clinical leaders irrespective of their professional backgrounds led me to consider the potential of kohitahitanga in illuminating the experiences of Māori clinical leaders. Subsequently, this prompted an expansion of the original boundaries of the literature review. In going back to studies relating to the experiences of Māori workforce, it was clear that the attributes and actions listed in studies on workforce significantly complement those described by studies on Māori health leadership.

Māori nurses have been found to hold a number of roles, which include advocacy, leading culturally safe practice and practicing in a values-based manner with key Māori concepts such as aroha and manaaki. They also face a number of challenges including working in the face of conflicting worldviews and increased emotional and cultural labour (Hunter & Cook, 2020; Kidd et al., 2020; Komene et al., 2023; Wilson, Barton, & Tipa, 2022), which link closely to findings from this study. Further, this study supported the finding that Māori clinical leaders identified leadership as a way to effect positive change for whānau and communities. A study by Wilson, Barton and Tipa (2022) found that many Māori are motivated to become nurses to improve healthcare delivery and outcomes for Māori, while in allied health Tofi (2022) comparably found that allied health

practitioners felt a sense of responsibility to Māori communities. There is very limited literature available directly on the experiences and skills of other workforces such as Māori allied health or kaiāwhina. However, a study by Tofi (2022) on Māori and Pacific allied health thriving in the first three years of practice noted 'extras' that came along with being Māori and Pacific that can be likened to leadership such as providing support to other clinicians.

When considering comparisons between literature about Māori clinical workforce and Māori clinical leaders, it is also important to note that expanding the Indigenous workforce in addition to Indigenous leadership is also necessary to reduce the inequitable burden of mortality and morbidity for Māori (Wilson, 2018). Findings of bravery and determination seem to be a potential point of difference between Māori workforce and Māori leadership.

The studies described above provide examples of research that acknowledged the diversity of Māori leadership and an ability to lead from the ground up. They provide a valuable contribution to the collective pūrākau and the articulation of Māori clinical leadership.

The Power of the Clinical Context

The decision to illuminate the pūrākau of clinical leaders limited to the scope of Crown health organisations was a source of uncertainty in the early stages of this research. A fact that I could not move past, and ultimately the deciding factor, is that Māori do not have options when they are acutely unwell and need to access hospital care. Although far from as abundant and well-resourced as needed, there are choices available in other areas of healthcare such as Māori led primary care services and Kaupapa Māori non-government organisation providers. Kōrero from W.A on not having enough kaimahi Māori within the hospital provided unprompted, similar thoughts to my own.

> *It leaves our whānau in strife, because they actually still need to come into hospital and if everyone here is not Māori, then there's no one here being their voice. Or engaging with them and they get put down as difficult to engage or not motivated… and they didn't feel like they were being heard. – W.A*

Our hospitals in Aotearoa are western Crown health organisations, and environments where Māori have negative experiences, experiencing marginalisation, higher rates of adverse events and racism that contribute to inequitable health outcomes (Graham & Masters-Awatere, 2020; Wilson & Barton, 2012). Māori *clinical* leaders are the kanohi kitea working directly with Māori accessing healthcare. Participants in this research identified numerous ways that they positively influence the care that Māori receive, including manaaki, making time for connection and sharing knowledge. Māori clinical leader participants acknowledged that Māori accessing healthcare are often at their

most vulnerable and described the powerful position of being able to directly support and improve their care.

Literature together with the voices of Māori clinical leaders suggest that a sense of agency and autonomy are important factors that impact Māori clinical leaders thriving in Crown health organisations. Investigations into a definition of clinical leadership to provide early context in this thesis described leadership that is hands-on, highly influential, values based and at the centre of the provision of care (Stanley & Stanley, 2018). Clinical leadership attributes include being supportive, approachable and effective communicators; being motivators and mentors for others and enacting values and beliefs on excellence, quality and behaviour (Braam et al., 2023). The combination of findings from literature review and kōrero with participants centred around Māori clinical leadership are congruent with these general 'mainstream' definitions of clinical leadership. Influence was clearly seen in the pūrākau of the participants. This was evidenced through the one-to-one support of patients to enable them to access care and in the mentoring of numerous Māori and Tauiwi health professionals in a variety of spaces. Both created ripples of change. They described aspects of leadership that were important to them, including whakamana of those around them, challenging the status quo, connection and collaboration. Participants clearly identified feeling a sense of responsibility to whānau and Māori accessing healthcare services, and recognised leadership as a way to enact change.

A recent report on the priorities of Māori health identified the problem that the autonomy of Māori leaders operating within institutions of the Crown is limited, particularly when reporting to non-Māori (Curtis et al., 2022). Despite identifying significant issues with the Crown health environments that they worked within, interestingly a lack of autonomy was not something that came through from the Māori clinical leaders. Although the positive nature of her comments was an anomaly, N.T went as far as describing an opposite scenario, where her whakaaro and suggestions were empowered on a yes-first philosophy from her non-Māori managers. In interactions with rangatahi and patients in clinical areas like ICU there was a sense of control in the expertise that clinical leaders held and certainly no question of asking for permission to act with te ao Māori values at the forefront. For a number of participants there was a sense of influence into numerous clinical areas through their tautoko of early career clinicians.

Literature on Māori clinical practice identified a lack of available time and a biomedical view that focuses on tasks rather than connection with patients, resulting in Māori nurses omitting usual cultural practices (Hunter & Cook, 2020; Wilson, Barton, & Tipa, 2022). Despite this, A.P reflected on skills learnt on the marae and in life at home that helped her to get around this. R.D also described a

point in her practice where she made the decision to put her values first, mimicking findings from Hunter and Cook (2020). Tipene (2017) noted similar findings in her public health leadership research. She described a theme titled "Doing Whatever It Takes" (p. 42) where participants explained that they often navigated perceived boundaries by working around them, being guided by Māori values while completing work tasks. A.P also projected a strong sense of self-direction and a tirelessness when it came to challenging the status quo, although at points of her story it was clear that her self-autonomy and success was due to a determination that gave managers above her little choice. It would be unrealistic to determine from these pūrākau that autonomy magically exists in clinical environments, however these stories do suggest that it is possible within the realm of clinical expertise and leadership, and that there is opportunity and power within clinical spaces to effect change.

Contemporary views of health leadership have, until recently, been that Pākehā doctors predominately hold leadership influence in healthcare in Aotearoa (Wiapo & Clark, 2022). Therefore, the power of Māori clinical leadership is an important point to make for those who continue to maintain the view that clinical leaders without job titles sit at the bottom of the hospital hierarchy and at the mercy of higher-up management. Clinical leadership, particularly Māori clinical leadership as it is reflected in this thesis, dispels the notion that to be a leader you need to be in a titled position. There is power in being the person who takes action and is seen taking action on a day-to-day basis. The whakataukī "mauri mahi, mauri ora; mauri noho, mauri mate" is often translated as "do the mahi, get the treats". Recently I heard this rearticulated as "the mauri is in the mahi", specifically in reference to clinical leadership. The mauri is in the mahi reinforces the idea that leading through action is a source of energy and strength (Berghan et al., 2024). T.U reinforces this idea throughout his pūrākau, giving power to the idea of being present and seen.

> *Recognition that leaders are predicated on action rather than title. What was very evident and when I think about my mates and their leadership capability it's the fact that they're there. – T.U*

Māori clinical leaders are in a unique position to be able to take action to influence the wider services they work within, feeling the mauri in the mahi, and reinforcing their mana from this.

The power of Māori clinical leaders in the clinical environment can, and should be, expanded through encouragement of Māori to be authentically themselves. Participants identified throughout their pūrākau the many different facets of their lives that strengthen their provision of care. These pūrākau highlighted that strong cultural foundations are important, however being authentic was more than an ability to demonstrate tikanga Māori; it was also about acknowledging their life

outside of mahi that includes tamariki, mokopuna and other important roles that give us a sense of self. These whakaaro are not reflected as factors essential for thriving in the literature, however this research has identified them as vitally important. Pipi et al. (2021) identified a sense of empowerment and whakamana as an outcome of the nursing and midwifery training programme Ngā Manukura o Apōpō, stemming from personal development and confidence as well as professional development. N.K and A.P described the multiple facets of a person that enable them to be who they are at work such as Māmā, artist and great cook. N.K identified that hospitals often have tunnel vision, declining to acknowledge kaimahi as a whole person. W.A reflected on how this is emphasised by clinical teaching from a western perspective that focuses on the separation between patient and health professional. Whanaungatanga and creating connections is an easily accessible way of understanding a person as a whole and giving confidence or whakamana to be that person at mahi.

A collective understanding

The Māori clinical leaders who shared their pūrākau in this research came from a variety of clinical backgrounds, including nursing, physiotherapy, social work, pharmacy and medicine. The common ground that they all shared was their whakapapa, and their desire to make improvements for the wellbeing of Māori. Participants identified being Māori first, with their professional identities following. This finding supports those from Komene et al., (2023) and Waiapo and Clark (2022), both of whom identified Māori first, nurse second within their publications. In existing literature, there is no research published to date on Māori leadership from an occupational therapy perspective, or physiotherapy, or any number of professions. I propose that Māori clinical leadership is a useful banner under which a broader scope of Māori leadership can be explored, minimising the need for ongoing investigation of leadership in individual professions. A collective understanding of the breadth and depth of Māori clinical leadership across professions will provide strength in achieving recognition and support.

As an example of how the umbrella of clinical leadership can provide a collective understanding, I have examined the whakapapa model of nursing leadership proposed by Wiapo and Clark (2022, p. 8), and reflected on where adaptation might be required to expand to consider other professional disciplines. This model has a number of strengths, one of which is the acknowledgement of the diversity in Māori leadership. They identified that each leader brings with them strands and perspectives, woven into the whiri or the backbone of a kete and consolidated by lived experience of being Māori nurse leaders. The strands identified are:

- **Strand one: Whakamana te tāngata** acknowledged the connections and networks that bring people together and the skill that this takes. The building of connection and reflection of the importance of teams was present throughout the pūrākau of the diverse clinical leaders in this research.
- **Strand two: I te wā tika me te waahi** reflected on historical Indigenous experiences. Participants in this research acknowledged colonisation. Although there was certainly evidence of clinical leaders both using past experience and looking towards the future, an element of this strand from Wiapo and Clark (2022) was also identifying the right time and space for change. Pausing to assess the most effective time was absent in the pūrākau above, although there was an element for U.T of being able to decide which approach would be most effective at any one moment (the lion or the lamb).
- **Strand three: Te whānau, te hapū, te iwi** recognised Māori communities, specifically thinking about the impact of varied perspectives including policy and strategy. As with strand two, policy and strategy were less present in the pūrākau, however the importance of diversity was emphasised throughout. Participants noted policy in terms of influencing change for whānau.
- **Strand four: Ngā piki me ngā heke** was most visible in the pūrākau of Māori clinical leaders through the discussion of wairua, and how many of them identified what it is that keeps them going and fills their cup. The whakapapa model linked the positives and negatives of leadership, along with finding the determination to continue, identifying what and who can help.
- **Strand Five: Tika, pono and aroha** had significant congruence between the whakapapa model and Māori clinical leadership pūrākau. This strand recognises the complexity of tika, pono and aroha, acknowledging the importance of collectivism in te ao Māori. Acting with integrity and with patients at the forefront was important to Māori clinical leaders.
- **Strand Six: Mana taurite** acknowledged the pursuit of equity as compelling, a driver that was pervasive throughout both the whakapapa model and Māori clinical leadership pūrākau. It is a reason for acting into leadership spaces, regardless of title or place in the medical hierarchy, putting in the time and effort to develop skill, and the why for many leaders in both studies.

In reviewing each of these strands, nursing as a profession is only referred to once in the original study, regarding the connections and networks that Māori nurses draw on. This is consistent with their findings of Māori first, nurse second. There are significant similarities between the strands described by Wiapo and Clark (2022) and elements of clinical leadership described in the pūrākau of

the Māori clinical leaders in this study. While originally developed with Māori nursing leadership in mind, the mauri of these strands extend beyond the confines of nursing practice to the lived experience of diverse Māori clinical leaders.

Strengthening self-identity

A clear finding from participants of this research is that mātauranga Māori is a key foundation for Māori clinical leadership. This mirrors ideas from other studies that recognise te ao Māori wisdom and the embodiment of tikanga as central in Māori leadership (Ruwhiu & Elkin, 2016; Tipene, 2017; Wakefield, 2023). Māori clinical leaders in this research spoke of the role models in their lives on the marae, of their kaumātua and wāhine toa teaching them about what it is to be a Māori leader. If we follow this thought process, does this mean that Māori who do not have this strong, marae-based upbringing are not as effective as leaders? This section aims to unpack this inference using wisdom from participants, illuminating it as something that was important to many of them and an important factor in supporting Māori clinical leaders to thrive. There are a number of potential perspectives and solutions that add layers of strength, solidifying the foundation of whakapapa.

Self-identity and effective leadership

Colonisation is a continual process, where one group imposes their ideas about the world onto another group, transferring power and privilege (Elkington & Smeaton, 2020). In her masters research looking at experiences of racism among non-stereotypical Māori, Arnold (2021) recognised that the processes of colonisation have shaped the formation of Māori identity, both through disconnection from culture and continual depiction of stereotypical features in texts and via media. This has resulted in spaces where those who have non-stereotypical features such as light-coloured hair and skin have their authenticity challenged (Arnold, 2021). Several participants identified feeling an impact from not looking the way Māori are perceived to look. This included experiencing overtly racist comments towards Māori from people expecting agreement, having their authenticity questioned or questioning it themselves, and feelings of being too Māori for some people simultaneously being too white for others.

Internalised racism was not something I had anticipated exploring in this thesis, however these excerpts from someone I view through her pūrākau as a strong Māori leader have made me consider the effect that internalised racism may be having:

> *I have these doubts… from a leadership space I'm getting asked to be the voice for Māori… sometimes I'm the only voice at the table… I question whether a little small Māori voice is better than no Māori voice. I've always struggled with being able to confidently say that I'm*

Māori… I think I have imposter syndrome! … I feel like I would, feel more legitimate almost, if I had the language. – W.A

Internalised racism is the acceptance of negative messaging about abilities and intrinsic worth as a minority (Jones, 2000). This includes feelings of shame or unworthiness because of repeated exposure to the perceived status of the dominant group or feeling cultural shame from internalising the view of Māori as inherently inferior (Moewaka Barnes et al., 2013; Walker et al., 2023). These doubts expressed above were not limited to just one participant. The judgement of herself as not good enough and feeling inferior based on societal perceptions of Māori meets the definition of internalised racism.

Like most of the Māori clinical leaders within this research, N.T provides a lot of mentoring and teaching in her role. She spoke about coming across Māori who did not believe that they were Māori enough in her pūrākau.

I think, Māori that have grown up in te ao Māori with tikanga Māori are very happy to put their names forward. Because they know the importance of sitting at the table. I find those that haven't grown up with te ao Māori and are on a journey, ah, they won't purely because they're dealing with stuff where they don't feel Māori enough to, to be the Māori representative in these spaces… in my mentoring roles I'm, you know just I'll sit next to them and I'll go, don't think like that, there's no such thing as Māori enough you either are or you aren't! – N.T

Moewaka Barnes et al. (2013) stated that internalised racism "ultimately limits the potential of Māori as it sets a pre-determined pathway for expectations and behaviours" (p. 74). Although N.T's example differs from those that Moewaka Barnes uses, it is reasonable to suggest that feeling not good enough to be Māori is an example of Māori self-limiting as a result of colonisation and internalised racism.

W.A identified one positive for advancing Māori perspectives at work, in that she was able to infiltrate and integrate into spaces where Māori may otherwise not be invited, or where she felt she was invited as someone who may be less challenging to the dominant group. The Māori clinical leaders who discussed not feeling enough never mentioned personal advantages to their situation, however there is privilege that comes alongside being socially assigned as white (Arnold, 2021) that also applies to health leaders. White privilege affords options, such as accessing otherwise inaccessible spaces, not experiencing direct interpersonal racism in the same ways as visibly Māori do, and an option to not divulge their whakapapa in places where they do not feel safe.

One consequence of being socially assigned as white can be understood through the lens of being colonised; the 'not enough' belief of Māori clinical leaders becomes a self-perpetuating kōrero that can prevent the building of their mana through the mauri in the mahi, limit leadership experiences and therefore progression.

Cultural and clinical education for Māori clinical leaders

Several of the participants in this study discussed the issues they faced with unequal access to both culturally based education and clinical education. At the same time, literature on Māori leadership frequently discusses Māori walking or navigating the two worlds of te ao Māori and te ao Pākehā (Hunter & Cook, 2020; Tipene, 2017; Wakefield, 2023; Wikitera, 2011). Te ao Māori has a collective approach to health with a holistic perspective, while te ao Pākehā is more individualistic and focuses on a bio-medical perspective (Hunter & Cook, 2020; Tipene, 2017). Te ao Pākehā is not only the perspective of the hospital environment that Māori leaders work within, but is often reflective of the perspectives of clinical professions (Tipene, 2017). Māori clinical leaders within this study spoke about the differences between Māori and Pākehā worldviews, identifying that it was the dominant western perspective that required that they compromise their Māori foundations. In a study of Māori nurses' experiences, Komene et al. (2023) identified the compromising of nurses cultural integrity as a regular occurrence in acute nursing practice.

Participating in education from cultural and personal development perspectives in addition to education to increase clinical skills can support Māori clinical leaders who are developing their cultural identity, and those who are working to strengthen Māori perspectives in clinical environments. The diversity of Māori society also requires diversity of leadership (Wikitera, 2011) and dual education in both cultural and clinical knowledge can support that. Ratima et al. (2007) make a brief mention of dual education in their review of Māori workforce development programmes, noting that it was a key success factor of interventions. Access to professional development is mentioned in literature on Indigenous workforce development and retention (Wilson, 2018). However, this is not often in relation to needing double the education of Tauiwi colleagues and there is a paucity of literature that identifies both cultural and clinical education as essential in the development of Māori clinical leadership.

During her kōrero W.A discussed the difficulties of accessing training from both perspectives, noting that Māori whaiora and whānau need expert clinicians, but that they also need the best cultural option.

> *Our Māori whaiora and whānau actually need expert clinicians rather than new graduates. They need people that are the best clinical and cultural option for them and that they're not*

having to choose between that as well. So I think actually investing in our Māori workforce does improve outcomes because you've got the engagement alongside the clinical knowledge. – W.A

She also spoke about a Māori colleague who recently completed some training when an opportunity to study rongoā came up. Their manager declined this request as they had already had their professional development allocation. W.A felt that this was a contributor her colleague leaving the Crown health organisation to move into private practice. She mourned the loss of a clinician who wanted to incorporate rongoā into practice, and the impact of this on patients who deserved high quality care.

Acknowledgement of the dual worlds where Māori leaders need to have multiple levels of expertise lends itself to a recommendation to recognise cultural as well as clinical education. I argue that if Māori leaders need to be experts in two spaces, they should receive support for training, teaching and professional development in both. This isn't something that participants in this research felt was happening now, identifying that the clinical perspective usually takes precedence. This was identified as worse in clinical areas where access to professional development is limited anyway.

With professional development opportunities you can go to a course a year, you can choose whether that's a cultural development or clinical development but it's usually not both. And often because of who's in leadership positions, they're pushing for the clinical side. – W.A

R.D identified the link between Indigenous studies and clinical studies, saying that if she was to do post-graduate study it would be in an Indigenous field.

I don't get why it's not clinical because that should be in all clinical things, Māori should. Well it is clinical, because when anything Māori comes up I've got people running to me about it. – R.D

This clearly suggests that Indigenous based education has clinical benefit. A.P reflected on completing postgraduate studies both as a stepping stone in her career, but also to tick some role requirement boxes that would then allow her to argue for learning that focused on mātauranga. Similarly to R.D she felt that it was mātauranga that was going to help her more in her role and help her to change the system. A number of participants noted that they were learning te reo Māori in their own time, with O.D reflecting that te reo Māori studies were a direct benefit to her Māori patients.

S.W clearly talked about wanting leadership education of any form, regardless of whether it was kaupapa Māori or western based, referring to training as 'arming herself' for the western leadership

world where the piece of paper that you have matters. She also identified that there is a no te ao Māori based health leadership education out there for people outside of nursing and midwifery.

W.A linked culturally based training to the retention of Māori staff, also noting the teaching that health professionals receive about equity, where patients may require more in the way of intervention to get to the same outcome. She suggests that putting more resource into Māori staff is simply necessary to get equitable outcomes for them.

> *That was because we were having equality in terms of training opportunities not equity for staff so I think one of the ways that you keep people is to offer them more leadership training or professional development, that you put more resources into our Māori staff so they can grow into excellent practitioners because our Māori whaiora and whānau actually need expert clinicians rather than new graduates. – W.A*

The concept of cultural loading is well known in Indigenous workforce literature (Komene et al., 2023). It is less documented in studies specifically on leadership, however participants in this study talked about cultural burnout and recognised a need to look after themselves in different ways. T.B also suggested that professional development plays a part in supporting these Māori clinical leaders.

> *If they have a specific development request or need for development… don't question it… little bits and pieces like that which might not feel massive but are huge to that person…. Some people can be a little bit resistant… but if you really want this person who you perceive as a cultural pou in your workforce, there are only so many blows that a pou can take before it comes down. Awhi and support and grown this pou instead of chopping it down… just giving that person what they need to develop in that space I reckon is the best thing we can do. – T.B*

N.T had remarkably similar sentiments, wishing to encourage Tauiwi managers to respect that Māori leaders know what they need and acknowledge that it sometimes requires courage to ask.

Invisible thresholds

It is widely acknowledged that to be a Māori leader you need to have skill in the application of tikanga (Forsha, 2017; Haar et al., 2019; McClintock et al., 2014; Tipene, 2017; Wakefield, 2023). However, it is untenable for multiple reasons to suggest that to be a leader there is a threshold of cultural knowledge or level of fluency in te reo Māori to reach. There are numerous publications on identity across professional spheres, looking into a multitude of factors. For example, Derby and Macfarlane (2018) considered the suggestion that those who are not fluent in te reo Māori are somehow "less Māori" (p. 220). Rather than a measurement of ability, which is impossible and

dangerously similar to blood quantum measurement (Derby & Macfarlane, 2018), a potential way forward implicit in the taonga from the Māori leaders is to foster a sense of belonging and whakamana. N.T's statement, "there's no such thing as Māori enough, you either are or you aren't" beautifully demonstrates whakamana and awhi for those who feel uncertain for whatever reason about the legitimacy of their ability to be a Māori leader.

Hornsey (2008) wrote about social identity theory in psychology, which considers how the groups that a person identifies with and belongs to influence their internal understanding of their own identity. This extends into a 'belonging hypothesis' – which acknowledges how essential a sense of belonging is for wellbeing (Hornsey, 2008). A.T specifically spoke in her pūrākau about trying to find a sense of belonging outside of the immediate western hospital environment she worked in, with Māori health services. She struggled with making connections and feeling like she belonged and as a result is mindful of supporting new Māori staff to establish these relationships.

For Māori leaders in public health, feeling connected to their culture through relationships supported them and fostered wellbeing (Tipene, 2017). Allied health clinicians in their first three years of practice identified that work settings that supported their cultural identity provided a sense of assurance which in turn enabled them to contribute authentically across their practice. Related to comments above about Māori self-limiting as a result of internalised racism, Tofi (2022) identified that empowering Māori and Pacific allied health professionals to incorporate their innate ways of being improved confidence and a sense of pride.

N.T noted that safe spaces for Māori such as marae or with mentors offer opportunities for practicing leadership skills, serving as stepping stones to leadership roles in less safe, "mainstream" spaces. W.A reported that her time at Ngā Manukura o Apōpō gave her a Māori space via marae and wānanga to learn where she did not need to worry about how others perceived her. She discussed Māori specific learning environments within her work in a Crown health organisation, but that these spaces were only for very short periods of time that didn't allow for in-depth connection. Pipi et al. (2021) supported W.A's personal insights in their review, identifying that the Ngā Manukura o Āpōpō clinical leadership training helped participants to feel able to speak out, stand up for themselves and able to manage challenging situations. Tipene (2017) agreed, recommending that Māori leaders find networks where they can express themselves, even if that meant expressing uncertainty.

Another facet of this multi-pronged issue is the perception that Tauiwi have of Māori identity. A.T identified within her pūrākau that it was her Tauiwi managers who perceived her as not Māori enough, rather than an internal belief that she held herself.

> *I'm also not good enough half the time. For a long time they would get people from Māori services to participate in interview panels. And things like that, because they needed a Māori on the interview panel and I'm like hello?! Hello?! I'm over here! I know I don't look it.*

One of the Māori clinical leaders in their pūrākau noted very accurately that leaders come in all shapes and sizes, identifying that this is something that Māori understand. In literature specifically on Māori leadership, Wikitera (2011) encourages multiple interpretations of Māori identity. Given the above story from A.T and earlier conclusions about the hierarchy that is pervasive in Crown health organisations it is not unreasonable to suggest that western perspectives of leadership are not as fluid and encompassing.

W.Y recognised Māori nurses who had different strengths and weaknesses throughout her years of mentoring, identifying that a key aspect of growing their leadership skill was in supporting them to identify those strengths and learn how to play to them. Another aspect she and W.K both identified was being part of a team of people who had different strengths to their own, and our ability to achieve more as part of a team. T.U noted that when it comes to leadership, there is an 'and-and' option, where there is space for all of us regardless of our approach. All of these ideas reinforce that Māori who are uncertain in their cultural identity can still contribute without needing to know everything or act in a certain way.

WHAIWHAKAARO

I have been writing about the thoughts of my participants in my discussion, but I feel like I'm talking about myself. When I talk about not needing to be raised on the marae to be a Māori leader, am I being self-serving and self-affirming? I decided that I am, but that doesn't mean that there isn't need. When I was re-reading transcripts and reading W.A in particular talk about whether she was enough, it really hammered home that this is something important to discuss. When I spoke to a Māori teammate at work about not looking Māori enough, she told me not to worry about it "I've got nieces who look like you, do you mean I should tell them they're not Māori enough?". It's my Pākehā colleagues who are the ones who say "really?! What percentage are you?" or tell me stories about their friend who was Māori, so they got a scholarship to uni. I had a chat about this dilemma with someone in my research whānau, who replied that it would be nice to have the choice. There goes my privilege again.

There is an affirming rhetoric that there is no such thing as being Māori enough and that all you need is whakapapa Māori to be Māori. This assurance did not appear to be enough for the Māori clinical leaders in this research who described that they did not have a solid upbringing in tikanga and reo. In addition to words, action is also required. Issues of self-identity are multi-faceted and would benefit from further exploration specifically in regards to the impact on willingness to take on leadership roles. Supporting Māori to feel like they belong offers a partial solution to uncertain cultural identity that is being driven by colonisation and racism. Participants themselves have identified connection, tuakana – teina relationships, cultural supervision and kaupapa Māori training as ways to improve confidence, all of which will support a sense of belonging to an identity of 'Māori' and encourage Māori clinical leaders who are uncertain about their contribution.

A commonality for each of the Māori clinical leaders who were included in this research was the desire to effect change for hauora Māori. This driver for leaders is so strong that it overcomes constant issues in the Crown health system such as racism and microaggressions. I believe that reacting to need in their communities and the fight to make the healthcare system better for their tamariki and mokopuna is also strong enough to overcome self-doubt. If you whakapapa Māori, and you want to make change – welcome to Māori leadership. This is supported by the findings described in the previous chapter of the grit and determination from the Māori clinical leaders. It reflects a holistic view of leadership that includes the ability to incorporate multiple experiences, good and bad (Wiapo & Clark, 2022).

I cannot conclude this section without highlighting a comment from O.D:

> *… the reality is for a lot of our babies it's not going to be the colour of their skin it's going to be what they feel within their hearts.*

This observation sets a wero for those currently in leadership spaces, to ensure that those mokopuna who follow us do not feel less able, but instead carry with them a sense of belonging regardless of the colour of their skin.

Whakatika

A significant proportion of this thesis is dedicated to acknowledging the change that Māori clinical leaders want to make for their communities and whānau. This pou of whakatika is inspired by the kōrero of the late Moana Jackson, and his thoughts on encouragement of restoration and making things tika as opposed to decolonisation (Jackson, 2020). It elaborates on the idea that Māori clinical leadership can act as an important tool in the overall process of whakatika through influencing and monitoring individuals, services, policy and systems.

Decolonisation has been defined early within this thesis as critical reflection, self-examination and action that breaks down the concept of Māori as other, normalising the Māori worldview (Elkington & Smeaton, 2020; Smith, 2012). At the beginning of this journey, I set out with the plan that this research would help to decolonise western views of leadership and contribute to decolonisation of the health system. There is so much to change, that at times it is impossible to imagine what a decolonised health system, complete with acute hospital care when it is needed, could look like. Moana Jackson acknowledged the overwhelming paralysis that can effect action, saying "courage is simply the deep breath you take before beginning." (Jackson, 2020). He also encouraged whakatika and restoration as opposed to decolonisation. I have come to realise during the process of this research that while decolonisation of the health system and root causes of inequity are so big that they require multiple deep breaths, it is essential to start making the first ripples.

The findings of this study clearly identified the colonial, western environments that Māori clinical leaders work within. However, it also clearly identified the passion that Māori clinical leaders have, to drive improvements and enable Māori hauora to flourish. An opportunity for Māori clinical leaders to be a part of decolonisation of the health system lies in their ability to lead actions towards whakatika.

The guide to He Korowai, Māori Health Strategy noted that "As part of enabling excellence in clinical care, effective Māori leadership is required to support health services to be accountable for continuing quality improvement." (Ministry of Health, 2014, p. 13). Came et al. (2020) identified a lack of accountability in both monitoring performance of the health system and in natural consequences such as decreased funding of those that were not effective. Evaluation of successes allows for the continued investment in the most effective resource that works. Evaluation of failures ensures that we are able to learn, receive feedback and make changes. A part of the current political agenda is rolling back any advances towards accountability, including disestablishing Te Aka Whai Ora, the structure tasked with monitoring and reviewing the Crown's progress towards its hauora Māori goals and priorities (Pae Ora Act, 2022).

One of the ways that Māori clinical leaders in this research identified monitoring and supporting accountability was in their participation on boards and advisory groups, noting that they held these roles in addition to clinical practice. They spoke about the levers that they have available to them, such as the cultural safety and cultural competency components required for annual practicing certificates (APC) in registered professions. In both board and advisory roles there was the opportunity to positively influence APC requirements and education of Tauiwi practitioners. Came, McCreanor, Haenga-Collins and Cornes (2019) found that many Māori participating on advisory

committees and in boards encountered numerous issues, such as needing to exert considerable effort to have their contributions heard. Within her pūrākau N.T acknowledged the difficulty of sitting around the board table, but was able to make a change:

> *What we've learned is that when… outside organisations come and ask if we could put forward an advisor from our association to sit on their organisations board or advisory board, we say yeah, that's fine but there's going to be three of them. Because there's no way we're sending one in there to sit and to be whakaiti, belittled in that space… I'm very unapologetic in these spaces when they want one person and we're going no. If you want us, you will have three.*

Another way the Māori clinical leaders identified providing monitoring and evaluation functions was in service evaluation and service design. This was sometimes formally requested and provided, and sometimes informal. O.D and R.D both shared kōrero around determining where need in their communities was not being met, therefore deciding where they should put their services. It is important to note that these clinicians were not in official team leader or service leader roles, however they clearly had the autonomy to initiate and carry out this work in their clinical roles. It appeared more common for Māori clinical leaders in community settings, however was not limited to community only. These Māori leaders identified that being close to the community and patients in clinical roles provides immediate and real-life feedback. They acknowledged that Māori do not necessarily all want to be treated the same way and showed an ability to adjust practice for the person in front of them.

A potential limitation of Māori clinical leadership in relation to accountability is their ability to have system-wide impact, an area where Te Aka Whai Ora could have had bearing had it been given the opportunity. This leads to the discussion of having Māori leadership at all levels, with W.K noting that at the time of her kōrero there was a Tauiwi CEO, and Tauiwi executive leadership in her organisation, getting to the next level down before there were Māori leaders. Current policy agrees, with Te Pae Tata Interim New Zealand Health Plan, the iGPS and Pae Tū Māori Health Strategy all describing Māori leadership (Minister of Health, 2023; Ministry of Health, 2022; Te Aka Whai Ora - Māori Health Authority & Te Whatu Ora - Health New Zealand, 2022). The iGPS describes how progress will be measured against priorities and included monitoring the number of Māori and Pacific peoples in leadership and governance roles across the Ministry of Health and health entities. The iGPS defined who this is, describing leadership and governance roles including boards, senior leadership teams and executive teams. A measure that is absent but that would be particularly useful is the number of Māori accessing kaupapa Māori leadership training. This would be in line

with both the aspirations in Te Pae Tata to strengthen and grow Māori leadership and with the recommendations from Māori leaders in this study.

Another avenue for system wide monitoring for the improvement of Māori clinical leadership is the Ngā Paerewa Health and Disability Services Standard (the Standard). The Standard describes best practice, aiming to foster continuous improvement in the quality of health and disability services (Standards New Zealand, 2021). Public hospitals, among other facilities, are audited against the Standard and receive certification (Ministry of Health, 2023). Auditing activity includes talking to whānau Māori and kaimahi Māori in order to assess compliance with standards such as 2.2.7 Service providers shall ensure their health care and support workers can deliver high-quality health care for Māori and 2.2.8 Service providers shall improve health equity through critical analysis of organisational practices (p. 40).

The designated auditing agency (DAA) handbook (Ministry of Health, 2023) describes requirements for auditing and audit reporting for certification of health care services. Within this handbook the requirements for an audit team are described. A critique of these requirements is their vagueness around the presence and inclusion of Māori auditors, noting only that the team makeup should be reflective of the cultural background of the service and people receiving the service. The standard requires inclusion of Māori in decision-making and implementation and provides opportunities for Māori clinical leaders to participate in higher level monitoring and accountability activity.

WHAIWHAKAARO

Digging deeper into meaning and intent around decolonisation has made me pause and consider what it is that I'm trying to do and what I mean when I talk about decolonisation. I read Imagining Decolonisation recently (Elkington & Smeaton, 2020), and felt so challenged by the idea that you can't decolonise a system that colonisation has established. "It's not about tweaking the existing colonial structure to make it more Indigenous-friendly or a little less oppressive" (p. 51). I worry that that's exactly what I'm trying to do – make the monster that is our health system in Aotearoa just a little less oppressive, and that it's not enough. At the same time, I don't completely agree. When I think about decolonisation in acute care I'm not thinking about completely knocking the hospital down, I'm thinking about taking all the good parts and making them so much bigger. Like the people who give 110% (the non-Māori consultant who rang Māmā about her scan results in the evening in the middle of a national state of emergency when he had every excuse not to), or the Māori health team who have to prioritise patients to get through their mahi, but will still sit with me for a cup of tea and chat, or show up to a meeting to tautoko a project even if they don't have time to fully participate.

Kupu Whakatepe

This discussion chapter has utilised the wisdom of Māori clinical leaders together with literature and contextual documents such as current health policy. It described factors that impact on thriving for Māori clinical leaders in Crown health organisations, identifying that a sense of agency and autonomy and the freedom to be their authentic self were important additional factors. I have proposed that Māori clinical leadership is a useful banner under which a broader scope of Māori leadership can be explored, minimising the need for ongoing investigation of leadership in individual professions.

In setting out to address the aim of articulating the full scope of Māori clinical leadership, I identified a collective pūrākau that detailed key ideas described by participants in this study across professional boundaries. This collective pūrākau prompted reflection on the similarities between participants kōrero, in spite of discipline or job title. With the intention of further strengthening knowledge about Māori clinical leadership, I also reviewed literature that more generally encompassed Māori healthcare workforce. A comparison of the two found a number of similarities including being values based and having a drive to make improvements for Māori. This discussion suggests that a collective understanding of the breadth and complexities of Māori clinical leadership across professions will provide strength in achieving recognition and support. Leadership collectively across workforce roles aligns well with Māori values of collectivism. Bringing the literature review findings together with research under the overarching concept of clinical leadership has strengthened a collective case for investment in the advancement of Māori clinical leadership in Crown health organisations.

I have identified that Māori clinical leaders are in a unique position to be able to take action to influence the wider services they work within, in part by creating the ripples that were identified as a subtheme in the findings chapter. Being able to take action and see change at a service level and in the individuals that they support reinforces their mana, feeling mauri from the mahi.

Recommendations to advance Māori clinical leadership include fostering a sense of belonging through relationships and connection, and by supporting dual avenues of training that will reinforce both cultural and clinical strengths. It is impossible to prioritise one type of training over another, both can support Māori clinical leaders to stand strong in their cultural identity and respond to the needs of patients.

The strengths identified throughout this thesis include: Foundations in whakapapa with compounding factors of common values in te ao Māori; the strength that te reo Māori brings; a

willingness and desire to create ripples, and an ability to weave cultural practices throughout clinical practice. The discussion chapter has identified that not only titled leaders act with the values of te ao Māori at the centre of their practice and recognised the leadership capability of the Indigenous health workforce. Ahakoa he iti, he pounamu.

CONCLUSION

This thesis began with an overview, describing a multi-faceted problem of inequitable access to healthcare for Māori, poor health outcomes, a marginalised Māori health workforce and lack of recognition for Māori clinical leaders. Through examination of historical contexts and systematic review of literature I positioned Māori clinical leadership as an important factor contributing to improvement for Māori health. These concluding remarks will list recommendations that link directly to factors that support Māori clinical leaders to thrive. It summarises key pieces of information essential to address the question, how should Māori clinical leaders be supported to thrive in Crown health organisations in Aotearoa?

Recommendations

Tūtohinga tuatahi

The first recommendation arising from this research is that Māori clinical leadership should act as an umbrella for Māori leadership in clinical professions, minimising the need for discipline specific research. An example of how knowledge can be expanded from leadership in one discipline to Māori clinical leadership was provided by comparing Waiapo and Clark's (2022) whakapapa model of nursing leadership to the findings of this research. It is important to note that this recommendation does not mean that discipline specific research should stop, however it does mean that existing research can be applied across a number of professions.

Tūtohinga tuarua

The second recommendation is that Crown health organisations invest in ongoing education for Māori clinical leaders that recognises the dual areas of clinical and cultural expertise they are expected to have. Allocation of ongoing education resource for Māori clinical leaders should reflect holistic development, which includes cultural education such as rongoā or te reo Māori *and* education that improves clinical expertise. This will require a policy change, where people managers no longer aim for 'fairness' in all their team members accessing the same amount or value of training. This recommendation echoes that of Tofi (2022), who found that opportunities for cultural development are a key factor for Māori and Pacific allied health practitioners to thrive in their first two years of practice.

This recommendation can be strengthened through monitoring the numbers of kaimahi Māori in Crown health organisations who access culturally based training, with an expectation of this number continuing to grow.

Tūtohinga tuatoru

The third recommendation comes directly from the Māori clinical leaders in this research and did not require interpretation. They were unified in recommending strongly that kaimahi Māori should have mentoring and support. This comes in different forms including kaupapa Māori supervision, tuakana-teina relationships and the presence of visible and relatable Māori leaders throughout organisational structures. This aligns with factors essential to thriving, such as the development of culturally safe and enriching environments.

A note about the second and third recommendations

Implementation of these recommendations together could have a powerful positive impact on self-confidence and self-identity for Māori in clinical positions. Action is required to whakamana Māori who did not have a solid upbringing in tikanga and te reo Māori, in order to continue to grow their capacity for Māori clinical leadership. Supporting Māori to feel like they belong offers a partial solution to those with an uncertain cultural identity, that is being driven by colonisation and racism. Participants themselves identified connection in the form of tuakana – teina relationships, cultural supervision and kaupapa Māori training as ways to improve confidence. All of which will support a sense of belonging to an identity of 'Māori' and encourage Māori clinical leaders who are uncertain about their contribution.

Tūtohinga tuawhā

This research has identified that a sense of autonomy and agency is a factor required for Māori clinical leaders to thrive in Crown health organisations. This recommendation therefore is that people leaders in Crown health organisations create and expand on opportunities for agency by fostering an environment of whakamana. This includes saying yes first in a variety of situations where cultural or clinical expertise is evident, such as service delivery improvement or individual patient care decisions.

This and other research identified that in many settings Māori clinical leaders are already adjusting their work as they see fit to provide care for Māori patients and whānau. They are technical experts in their fields of practice and for many participants this resulted in them already having this sense of agency. This therefore also becomes a recommendation not just for Crown health organisations but for those researching, writing or talking about clinical spaces. Māori working within clinical environments should be recognised as the technical experts that they are who have the power to influence change and as opposed to only as people who are at the mercy of colonisation and racism.

Tūtohinga tuarima

The final recommendation is that monitoring activity to hold Crown health organisations accountable for the growth of the Māori health workforce is continued and strengthened. In national documents such as the iGPS that are measuring numbers of Māori leaders on boards, in senior leadership teams and in executive leadership teams, this measurement can be further strengthened by expanding on definitions of leadership. Separately including Māori leaders in titled clinical roles such as clinical nurse manager, team leader, senior medical officer and so on does exclude key clinical leaders who do not have a title; however it will reflect a wider perspective of leadership and reflects recommendations of Māori leadership at all levels.

Monitoring recommendations include involving Māori clinical leaders in activity such as certification audits. This research identified a limitation in auditing of hospitals against the Ngā Paerewa Health and Disability Services Standard, whereby there are only vague requirements for the makeup of the auditing team, and there are limited opportunities for Māori clinical leaders to provide feedback in a safe way where they are not identifiable.

Implications for practice

The recommendations described above have been driven by the pūrākau of Māori clinical leaders, and all relate to how participants wanted to be supported to thrive in Crown health organisations. If thriving can be achieved, there is significant potential transformation of the health system.

A vital question and aspect of kaupapa Māori philosophy and research is, *who will this research benefit?* It was one of the first questions that Kaumātua asked in the early planning stages of this work. This research has significant, and far-reaching implications, from the Māori clinical leadership workforce to the kaimahi Māori in their teams, the patient receiving high quality care founded in Māori ways of being and their whānau who have positive experiences with health.

More immediately, this research provides an evidence base around what constitutes as thriving for Māori clinical leaders and what factors are essential to focus attention towards. It gives weight to national documents such as the National Workforce Plan 2024 that identified kaimahi Māori thriving as a goal. Importantly, it has provided Crown health organisations with evidence from Māori clinical leaders, founded in mātauranga that moves beyond the absence of racism.

Overall, Māori clinical leaders in this research have demonstrated that a key driver for them is enacting change. They act as a tool towards Indigenising healthcare provision in Crown health organisations and do so in less than ideal environments. If Māori clinical leaders are truly supported to thrive, they could make even greater positive shifts in healthcare practices, policies, and outcomes.

This thesis established early on that Māori leadership in health has many positive impacts. These include expansion and retention of Indigenous workforce and improving the experience of Māori receiving healthcare. It identified that the right leadership is important to enable and advocate for teams to thrive and to achieve Māori health equity and wellbeing.

A final implication for practice as a direct result of this research is in the validation of experiences of Māori clinical leaders, who often described feeling alone. When speaking with participants and in presentation of early findings to an Indigenous group or to Māori working in health, I realised that many of these findings were not news to them. What they do and what I hope they will continue to do, is to tautoko, uplift and illuminate the experiences that Māori clinical leaders have every day. The implications of this validation of the ongoing mahi of Māori clinical leaders should not be underestimated.

Limitations

The scope of this study was limited to examination of Māori clinical leadership in Crown health organisations and did not venture into Māori clinical leadership in kaupapa Māori health services, NGO or primary health care. Investigation into these spaces may uncover additional perspectives that could build a full picture of Māori clinical leadership thriving in wider healthcare settings in Aoteaora.

This research has been able to draw conclusions on the collective experience of Māori clinical leaders across professions. These findings could be strengthened through specific comparator studies.

A limitation of this study is that it looks toward Māori clinical leaders to find solutions for a problem that is founded in colonisation. Although these solutions come from Māori, recommendations are firmly directed towards Crown health organisations, acknowledging that it is not the job of Māori to fix the system and we must not expect Māori leaders to be the only or primary catalyst for improvement.

Future research

A key idea arising for many of the Māori clinical leaders within this research was the issue of self-identity. Issues of self-identity are multi-faceted, requiring more attention than was possible within this study, however, it appears that concerns of ‘being Māori enough’ are pervasive and are likely impacting the willingness of Māori to take on leadership roles or responsibilities. Further exploration in regard to developing confidence in self-identity to continue to grow the Māori leadership workforce would be beneficial.

Evident within the pūrākau of participants are pockets of excellence in people management, which includes that of non-Māori allies. Further research that looks to non-Māori for the solution to issues of recruitment, retention and development of Māori leaders in Crown health organisations would be beneficial to build on the knowledge that Māori clinical leaders have shared. Ideally this would include exploration of the impact of implementing the recommendations proposed in this research.

Kupu Whakamutunga

I entered into this research having witnessed in practice the strength and dedication that Māori clinical leaders demonstrate, even within difficult environments. This perspective has been reinforced through every pūrākau, identifying this workforce as powerful, improving the experience of Māori who they interact with and improving the services and teams that they work in.

They go to work every day to make their services better and to make a difference for Māori and their whānau who are accessing care because they have no other choice. Māori clinical leaders who stay working in Crown health organisations don’t stay for themselves, they stay because they have a goal to see Māori flourishing. Mokopuna who grow up not scared to visit the hospital. Māori who go to the hospital to get the treatment that they deserve, from people who care about them. Creating a place that feels familiar, not just the place where Nan died.

It is fitting that the final words of this thesis should come from a participant of this study.

> *This is for me, for my whānau, for my mokopuna.* - O.D

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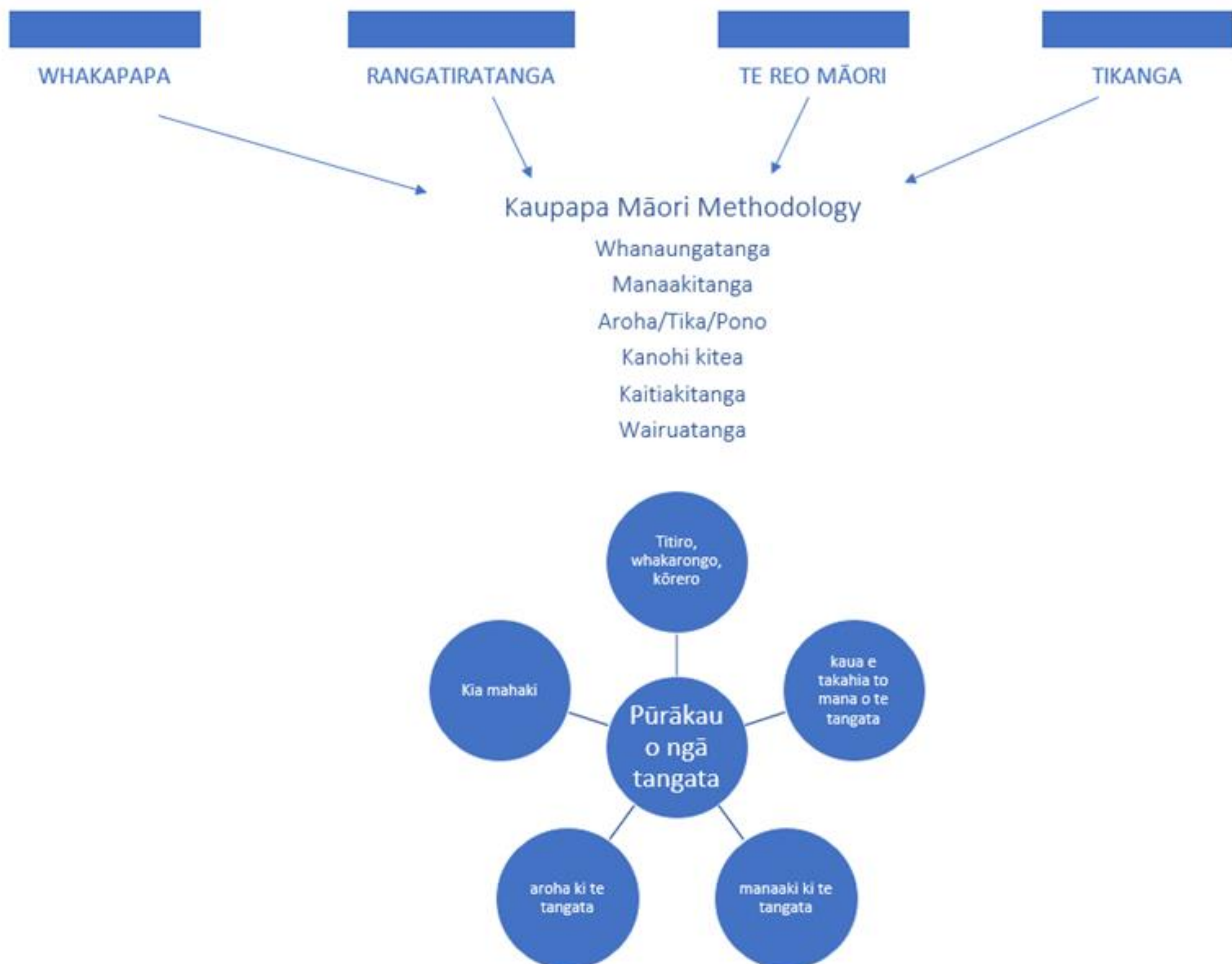
APPENDICES

Appendix A: Literature review table of results

Author, Year	Title	Publication Type
Baker, 2009	Developing the Māori nursing and midwifery workforce.	Journal article
Brockie et al., 2023	Indigenous social exclusion to inclusion: Case studies on Indigenous nursing leadership in four high income countries.	Journal article
Came et al, 2019	Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand.	Journal article
Forsha, 2017	Tikanga Māori – lessons in leading.	Journal article
Gifford et al., 2010	Māori challenges and Crown responsibilities: Māori policymaker ideas on smokefree policy options.	Journal article
Haar et al., 2019	Indigenous insights into ethical leadership: A study of Māori leaders.	Journal article
Katene, 2010	Modelling Māori leadership: What makes for good leadership?	Journal article
McClintock et al., 2014	Contributing to Māori leadership in health.	Journal article
Munro, 2016	Pae ora, policy and Māori leadership	Thesis
Panesar et al., 2021	Indigenous health leadership: A kaupapa Māori perspective from Aotearoa.	Journal article
Panoho, 2012	A Māori-centred inquiry into health governance: Māori directors on district health boards.	Thesis
Pipi et al., 2021	Ngā Manukura a Āpōpō: Sustaining kaupapa Māori nurse and midwifery leadership	Journal article
Sampson, 2019	What does it mean to be a Māori doctor? Historical and contemporary perspectives.	Thesis
Severinsen et al., 2021	COVID-19 and Indigenous knowledge and leadership.	Journal article
Tipene, 2017	Māori public health practitioners' views of Māori leadership in the public health context.	Thesis
Wakefield, 2023	Investigating Māori nurse leaders' experiences within nursing	Thesis
Waipo and Clark, 2022	Weaving together the many strands of Indigenous nursing leadership: Towards a whakapapa model of nursing leadership.	Journal article
Wikitera, 2011	Travelling, navigating and negotiating Māori leadership challenges in the 21st century	Journal article
Winiata, 2012	Leadership styles and nursing in a whānau ora context.	Journal article

Appendix B: Early iterations of figure 1



Appendix C: AUTEC approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

15 November 2022

Karen Webster
Faculty of Health and Environmental Sciences

Dear Karen

Re Ethics Application: **22/299 Supporting Māori clinical leaders to thrive in Crown health organisations**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 15 November 2025.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: Tracy.murphy@hbdhb.govt.nz; jan.dewar@aut.ac.nz

Appendix D: Locality authorisation sign off

Te Whatu Ora Health New Zealand	CHECK LIST FOR RESEARCH LOCALITY AUTHORISATION SIGN OFF

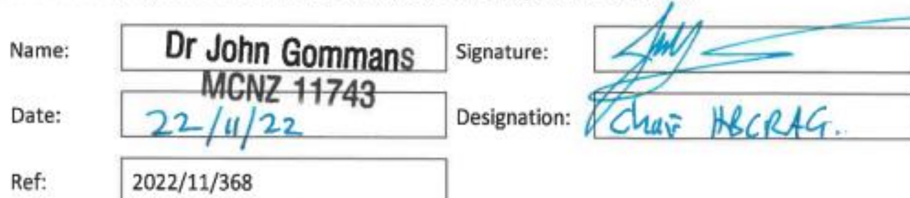
Received: 16 Nov 2022

Name of Principal Investigator: Tracy Murphy

Full Project Title: How should Maori clinical leaders be supported to thrive in Crown health organisations in Aotearoa

DOCUMENTATION	COMMENTS / DOCUMENTS CITED	DATE	SIGNED
Statement of maintaining Patient Confidentiality	Stated in PISICF	22 Nov 22	M Spooner
Summary of Protocol/Proposal	Cited	22 Nov 22	M Spooner
Participant Information & Consent Forms	Cited	22 Nov 22	M Spooner
Evidence of Cultural Consultation	Approval gained By Ngaira Harker	22 Nov 22	M Spooner
Evidence of approval from student supervisor (for academic research)	N/A		
Evidence of academic institutional review & approval (for academic research)	N/A		
Service Manager / Clinical Director / Nurse Director approval	Approval gained Ann McLeod	22 Nov 22	M Spooner
Contract or Agreement	N/A		
Request for data from IS	N/A		
HDEC Ethical review undertaken	AUTEC 22/299	15 Nov 22	M Spooner
Research spreadsheet updated	Updated	22 Nov	M Spooner

Te Whatu Ora – Te Matau a Maui Hawkes Bay Research Review
The research project has been reviewed with the following prior to approval:



Name:	Dr John Gommans MCNZ 11743	Signature:	
Date:	22/11/22	Designation:	Chair HBCRAG.
Ref:	2022/11/368		

Appendix E: Kaumātua letter of support

30 September 2022

AUT: Auckland University of Technology
55 Wellesley Street East
Auckland Central

RE: Tracy Murphy

To Whom It May Concern

Kia ora

Re: Research Proposal Consultation with Tracy Murphy

As the Pouahurea & Kaumatua at the Whatu Ora ki Te Matau-a-Maui/Health NZ at Hawkes' Bay, I have had the pleasure of knowing and working alongside Tracy over the past four years in our respective roles. Tracy has successfully applied and practiced our organisational core values in her work, including He Kauanuanu (Respect), Tauwhiro (Care), Ākina (Improvement), Rāranga te Tira (working together) which is integral to her leadership role to develop collegiality thru-out our organisation. These values shape who we are at the Te Whatu Ora ki Te Matau-a-Maui and Tracy is the epitome of someone who reflects these values through her actions, behaviour and interactions, especially thru supporting whānau members of our patients in her care. Her presence, personality and unique perspective has been a great asset within her current team of Planning, Funding & Performance and has continued to influence others throughout the wider community and our organisation.

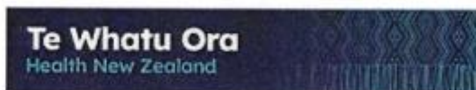
Tracy has demonstrated and maintained high levels of work and study standards that I believe will enable her to influence this organisations future and provide a solid foundation for her future workforce pathway for not only herself, but also the pathway of her co-workers.

Tracy has been diligent in respect to maintaining a high degree of accuracy while preparing her research proposal for the AUT Doctor of Health Science qualification, titled: How should Māori clinical leaders be supported to thrive in Crown health organisations?

I can confirm that Tracy has consulted with me and that I am more than delighted to continue my support for her research.

Kind regards

Hawira Hape | Pouahurea (Principal Cultural Advisor) & Kaumātua | Te Aka Whai Ora
Gate 11, Omahu Road | Private Bag 9014, Hastings 4156
Waea pūkoro: +64 27 203 2259 | Nama Waea: +64 6 878 1654 ext: 5786 | **Īmēra: hawira.hape@hbdhb.govt.nz**



Appendix F: Participant information sheet

Participant Information Sheet

Supporting Māori clinical leaders to thrive in Crown health organisations

15 November 2022

Tēnā koe,

He uri ahau no NgāPuhi. Ko Ngati Hinera me Te Uri Taniwha ngā hapū. Ko Tracy Murphy tōku ingoa.

I am a Doctor of Health Sciences student at Te Wānanga Aronui o Tāmaki Makau Rau, Auckland University of Technology, and work at Hawke's Bay Hospital in the Planning, Funding and Performance team. I am an occupational therapist and live in Napier with my whānau. The information provided in this sheet is to support you to decide whether you would be interested in participating in the research I am completing. Please feel free to contact me with any further questions at any stage, or if you would like to have a conversation with me prior to deciding to participate. The most important thing is that you feel comfortable and well informed to decide whether you would like to take part.

What is the reason for this research?

In the public health system in Aotearoa Māori patients receive inequitable access to interventions and quality of care and experience the worst health outcomes of any population in New Zealand. Sadly, there is strong evidence that Māori working within publicly funded healthcare systems in Aotearoa can feel like foreigners themselves, experiencing discrimination, microaggressions and racism. Our recent health reforms have identified that Māori leadership at all levels is essential for improvement of health inequities, however retention of Māori clinicians is an issue.

Why clinical leadership?

Leadership for Māori is values based and not always defined by job description or title. Clinical leaders are central to the provision of good quality care and influence those around them to continually improve the care they provide, despite this, there is very little research into Māori clinical leadership in Aotearoa. Maintaining Māori cultural values and Māori views of health while working in a western health system are important aspects of Māori leadership that present personal and professional challenges to Māori leaders in healthcare.

Through this research I hope to articulate the full scope of Māori clinical leadership and to understand Māori clinical leaders' aspirations for support and growth. The intention is to influence and improve the Crown health environments that Māori work within.

How was I identified and why am I being invited to participate in this research?

Many Māori clinicians would not necessarily identify themselves as leaders. Because of this, I have chosen a style of recruitment called snowballing, where participants of the research identify others whom they consider to be a leader in their clinical area. Each participant is asked to pass on my contact information and information about the research project. You have received this invitation because you work in a Crown health organisation in Aotearoa and demonstrate te Ao Māori values of leadership in your clinical practice.

You may be excluded from this research if: you have been supervised or employed by myself as the researcher, your area of leadership does not have a clinical focus or you work within a Kaupapa Māori or Non-government organisation rather than a Crown health organisation.

How do I agree to participate in this research?

You can contact me directly via email tracy.murphy@hbdhb.govt.nz or via phone or text: 021 210 3364. If you email or text me, I will contact you and if you are interested in taking part, we can arrange a time and location that you feel most comfortable for a discussion relating to your clinical leadership story. I will travel to you or alternatively am also happy to have conversations via zoom/teams if you prefer. The discussion will take between 60-90 minutes, and I will ask you to sign a consent form. I will be audio recording discussions, and I will check with you before I start recording.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Your major contribution to this project will be through sharing your story of clinical leadership with me. Our kōrero will follow a process of whanaungatanga and discussion of the whakapapa of the research. I will not have formal questions, the discussion will be based around your experiences and whakaaro (thoughts), these may be positive experiences of support and environments that allowed you to grow as a leader, or they may be negative experiences.

I will be sending audio recordings to a transcriber, and you will have the opportunity to check your transcription including choosing to delete or change any information you have provided. All identifying information will be kept confidential, and interviews will take place with participants from different regions throughout New Zealand. If you feel that you have provided information that may make you identifiable, you can choose to completely omit these from the transcript. It is important to know that you can still choose to remove yourself from the research at this point.

If you consent, once I have completed all kōrero and established some early themes I would like to share these with you for a further conversation to check that these resonate with you as a clinical leader. I will also have support from Kaumātua to review themes and analysis. This is not a compulsory or expected part of the research and you can choose to be advised only of the results if you prefer.

What are the risks in taking part?

While it is not intended that you would experience any discomfort psychologically or emotionally from participating in this research, experiences of racism and discrimination within our health system are unfortunately a reality. You will be able to stop our kōrero at any point if you feel uncomfortable for any reason. If there was an issue that arose during our discussion we would work through the most appropriate option for support, whether that be Kaumātua or cultural support or services such as Employee Assistance Programmes (EAP).

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

By taking part in this research you will be helping to identify ways that clinical leaders working in Western systems can be supported. Your participation will inform and contribute to the development of a thesis and relevant publications celebrating Māori clinical leadership. A $50 prezzie card will also be provided for each interview completed as recognition of your time and input into this study.

How will my privacy be protected?

Audio files and transcription files will be securely stored on a password protected computer for six years. All identifying information will be removed prior to sharing these with academic supervisors. Transcription services do not keep a copy of audio files or transcribed interviews. Your personal information will only be used for the purposes of this research.

What are the costs of participating in this research?

By participating in this research, you will be agreeing to contribute your time. I am anticipating that kōrero will take between 60-90 minutes. Other time commitments include reading of your transcript, and participation in reviewing initial themes.

What opportunity do I have to consider this invitation?

Participant recruitment for this study will be completed by March 2023. If you are interested in participating, please make contact as soon as you are able.

Will I receive feedback on the results of this research?

Once the study is completed, I will email you a summary of findings – or alternatively you will be able to download the full thesis from the AUT library website.

Once the study is completed, I will email you a summary of findings – or alternatively you will be able to download the full thesis from the AUT library website.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor

Dr Karen Webster
karen.webster@aut.ac.nz
(+649) 921 9999 ext 6745

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. If you are interested in participating or have further questions you are also able to contact the research team as follows:

Researcher Contact Details:

Tracy Murphy
tracy.murphy@hbdhb.govt.nz
027 210 3364

Project Supervisor Contact Details:

Dr Karen Webster
karen.webster@aut.ac.nz
(+649) 921 9999 ext 6745

Approved by the Auckland University of Technology Ethics Committee on 15 November 2022, AUTEC Reference number 22/299.
ethics@aut.ac.nz (+649) 921 9999 ext 6038

Appendix G: Participant recruitment email

Email pānui

Subject: Research invitation

Attachments: Participant information sheet, participant consent form

Tēnā koe

He uri ahau no NgāPuhi. Ko Ngati Hinera me Te Uri Taniwha ngā hapū. Ko Tracy Murphy tōku ingoa.

I am a Doctor of Health Sciences candidate at Te Wānanga Aronui o Tāmaki Makau Rau, Auckland University of Technology, and work at Hawke's Bay Hospital in the Planning, Funding and Performance team. I am an occupational therapist and live in Napier with my whānau.

You are invited to be an early participant in a research study: Supporting Māori clinical leaders to thrive in Crown health organisations.

Attached and copied below is a detailed information sheet, which covers what participation will entail, what the risks and benefits to participants may be, management of privacy and data and who to contact should you have any concerns.

The information provided below is to support you to decide whether you would be interested in participating in the research I am completing. Please feel free to contact me with any further questions at any stage, or if you would like to have a conversation with me prior to deciding to participate. The most important thing is that you feel comfortable and well informed to decide whether you would like to take part. If you are interested, you can contact me directly via email: tracy.murphy@hbdhb.govt.nz or via phone or text: 027 210 3364.

Ngā mihi nui

Tracy Murphy

Supporting Māori clinical leaders to thrive in Crown health organisations

Participant information

What is the reason for this research?

In the public health system in Aotearoa Māori patients receive inequitable access to interventions and quality of care and experience the worst health outcomes of any population in New Zealand. Sadly, there is strong evidence that Māori working within publicly funded healthcare systems in Aotearoa can feel like foreigners themselves, experiencing discrimination, microaggressions and racism. Our recent health reforms have identified that Māori leadership at all levels is essential for improvement of health inequities, however retention of Māori clinicians is an issue.

Why clinical leadership?

Leadership for Māori is values based and not always defined by job description or title. Clinical leaders are central to the provision of good quality care and influence those around them to continually improve the care they provide, despite this, there is very little research into Māori clinical leadership in Aotearoa. Maintaining Māori cultural values and Māori views of health while working in a western health system are important aspects of Māori leadership that present personal and professional challenges to Māori leaders in healthcare.

Through this research I hope to articulate the full scope of Māori clinical leadership and to understand Māori clinical leaders' aspirations for support and growth. The intention is to influence and improve the Crown health environments that Māori work within.

How was I identified and why am I being invited to participate in this research?

Many Māori clinicians would not necessarily identify themselves as leaders. Because of this, I have chosen a style of recruitment called snowballing, where participants of the research identify others whom they consider to be a leader in their clinical area. You have received this invitation because you work in a Crown health organisation in Aotearoa and demonstrate te Ao Māori values of leadership in your clinical practice.

How do I agree to participate in this research?

You can contact me directly via email tracy.murphy@hbdhb.govt.nz or via phone or text: 027 210 3364. If you email or text me, I will contact you and if you are interested in taking part, we can arrange a time and location that you feel most comfortable for a discussion relating to your clinical leadership story. I will travel to you or alternatively am also happy to have conversations via zoom/teams if you prefer. The discussion will take between 60-90 minutes, and I will ask you to sign a consent form. I will be audio recording discussions, and I will check with you before I start recording.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Your major contribution to this project will be through sharing your story of clinical leadership with me. Our kōrero will follow a process of whanaungatanga and discussion of the whakapapa of the research. I will not have formal questions, the discussion will be based around your experiences and whakaaro (thoughts), these may be positive experiences of support and environments that allowed you to grow as a leader, or they may be negative experiences.

I will be sending audio recordings to a transcriber, and you will have the opportunity to check your transcription including choosing to delete or change any information you have provided. All identifying information will be kept confidential, and interviews will take place with participants from different regions throughout New Zealand. If you feel that you have provided information that may make you identifiable, you can choose to completely omit these from the transcript. It is important to know that you can still choose to remove yourself from the research at this point.

If you consent, once I have completed all kōrero and established some early themes I would like to share these with you for a further conversation to check that these resonate with you as a clinical leader. I will also have support from Kaumātua to review themes and analysis. This is not a compulsory or expected part of the research and you can choose to be advised only of the results if you prefer.

What are the risks in taking part?

While it is not intended that you would experience any discomfort psychologically or emotionally from participating in this research, experiences of racism and discrimination within our health system are unfortunately a reality. You will be able to stop our kōrero at any point if you feel uncomfortable for any reason. If there was an issue that arose during our discussion we would work through the most appropriate option for support, whether that be Kaumātua or cultural support, services such as 1737 or occupational health.

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only

available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- *drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.*
- *let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.*

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

By taking part in this research you will be helping to identify ways that clinical leaders working in Western systems can be supported. Your participation will inform and contribute to the development of a thesis and relevant publications celebrating Māori clinical leadership. A $50 prezzie card will also be provided for each interview completed as recognition of your time and input into this study.

How will my privacy be protected?

Audio files and transcription files will be securely stored on a password external storage device for six years. Transcription services do not keep a copy of audio files or transcribed interviews. Your personal information will only be used for the purposes of this research.

What are the costs of participating in this research?

By participating in this research, you will be agreeing to contribute your time. I am anticipating that kōrero will take between 60-90 minutes. Other time commitments include reading of your transcript, and participation in reviewing initial themes.

What opportunity do I have to consider this invitation?

Participant recruitment for this study will be completed by March 2023. If you are interested in participating, please make contact as soon as you are able.

Will I receive feedback on the results of this research?

Once the study is completed, I will email you a summary of findings – or alternatively you will be able to download the full thesis from the AUT library website.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor

Dr Karen Webster

karen.webster@aut.ac.nz

(+649) 921 9999 ext 6745

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, ethics@aut.ac.nz , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

If you are interested in participating or have further questions you are also able to contact the research team as follows:

Researcher Contact Details:

Tracy Murphy
tracy.murphy@hbdhb.govt.nz
027 210 3364

Project Supervisor Contact Details:

Dr Karen Webster
karen.webster@aut.ac.nz
(+649) 921 9999 ext 6745

Approved by the Auckland University of Technology Ethics Committee on 15 November 2022, AUTEC Reference number 22/299. ethics@aut.ac.nz (+649) 921 9999 ext 6038

Appendix H: Participant consent form, in person

Consent Form

For use with face-to-face kōrero.

Project title:	***Supporting Māori clinical leaders to thrive in Crown health organisations***
Project Supervisor:	***Dr Karen Webster, Dr Jan Dewar***
Researcher:	***Tracy Murphy***

○ I have read and understood the information provided about this research project in the Information Sheet dated 15 November 2022

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I wish to be contacted about early research themes for comment and/or feedback (please tick one):
Yes○ No○

○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: ....

Participant's name: ....

Participant's Contact Details (if appropriate):

....

....

....

....

Date:

Approved by the Auckland University of Technology Ethics Committee on 15 November 2022 AUTEC Reference number 22/299

Note: The Participant should retain a copy of this form.

Appendix I: Oral consent form

Oral Consent Protocol

For use when kōrero are via videoconference.

Project title: ***Supporting Māori clinical leaders to thrive in Crown health organisations***

Project Supervisor: ***Dr Karen Webster, Dr Jan Dewar***

Researcher: ***Tracy Murphy***

The participant joins the videoconference

○ Do you agree to my recording your consent to participate?

If they agree, then the record function will be activated and they will be asked the following:

○ Have you read and understood the information provided about this research project in the Information Sheet dated 15 November 2022?

○ Do you have any questions about the research?

○ Do you understand that notes will be taken during the interviews and that the interview will also be audio-recorded and transcribed?

○ Do you understand that taking part in this study is voluntary (your choice) and that you may withdraw from the study at any time without being disadvantaged in any way.?

○ Do you understand that if you withdraw from the study then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used? However, once the findings have been produced, removal of your data may not be possible.

○ Do you agree to take part in this research?

○ Do you wish to receive a summary of the research findings? (please tick one): Yes○ No○

○ Do you want me to send you a copy of the audio recording for this consent? Yes○ No○

○ Please confirm you name and contact details

Participant's name: ....

Participant's Contact Details (if appropriate):

....

....

....

....

I will now turn off the recording of the Consent and then will start a separate recording for the interview.

Approved by the Auckland University of Technology Ethics Committee on 15 November 2022 AUTEC Reference number 22/299

Note: The Participant should retain a copy of this form

Appendix J: Transcriber confidentiality agreement

Confidentiality Agreement

Project title: *Supporting Māori clinical leaders to thrive in Crown health organisations*

Project Supervisor: *Dr Karen Webster*

Researcher: *Tracy Murphy*

- ✓ I understand that all the material I will be asked to transcribe is confidential.
- ✓ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ✓ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name: ....Shoba C Nayar...

Transcriber's Contact Details (if appropriate):

...snayar19@gmail.com...

....

....

....

Date: 19/11/2022

Project Supervisor's Contact Details (if appropriate):

....

....

....

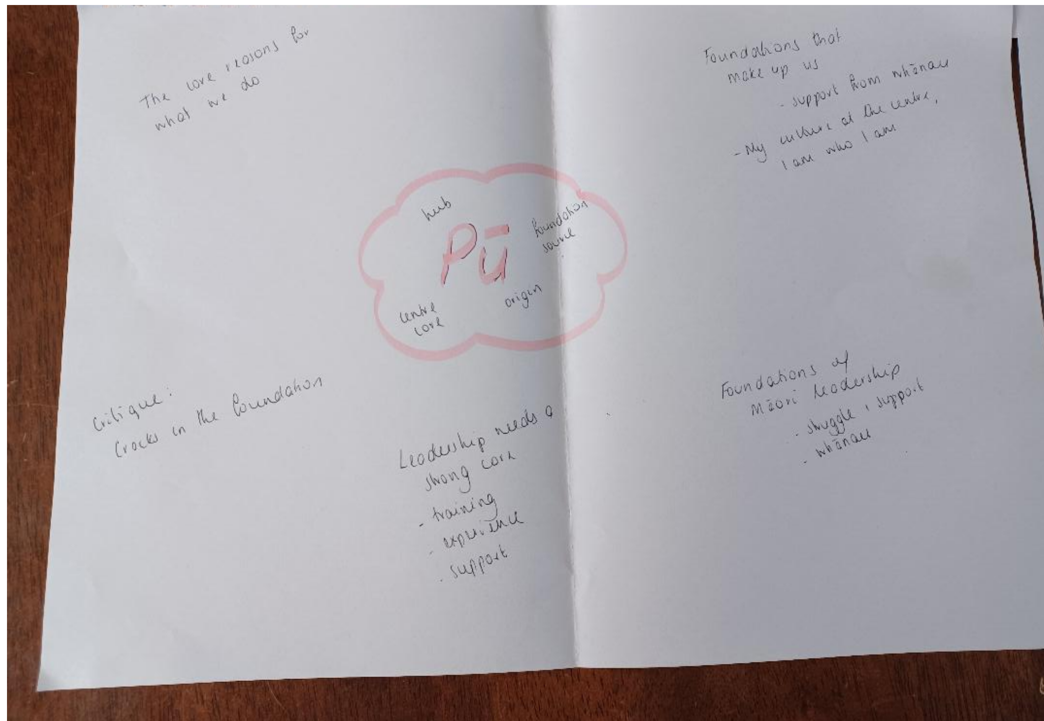
....

Approved by the Auckland University of Technology Ethics Committee on 15 November 2022, AUTEC Reference number 22/299. ethics@aut.ac.nz (+649) 921 9999 ext 6038

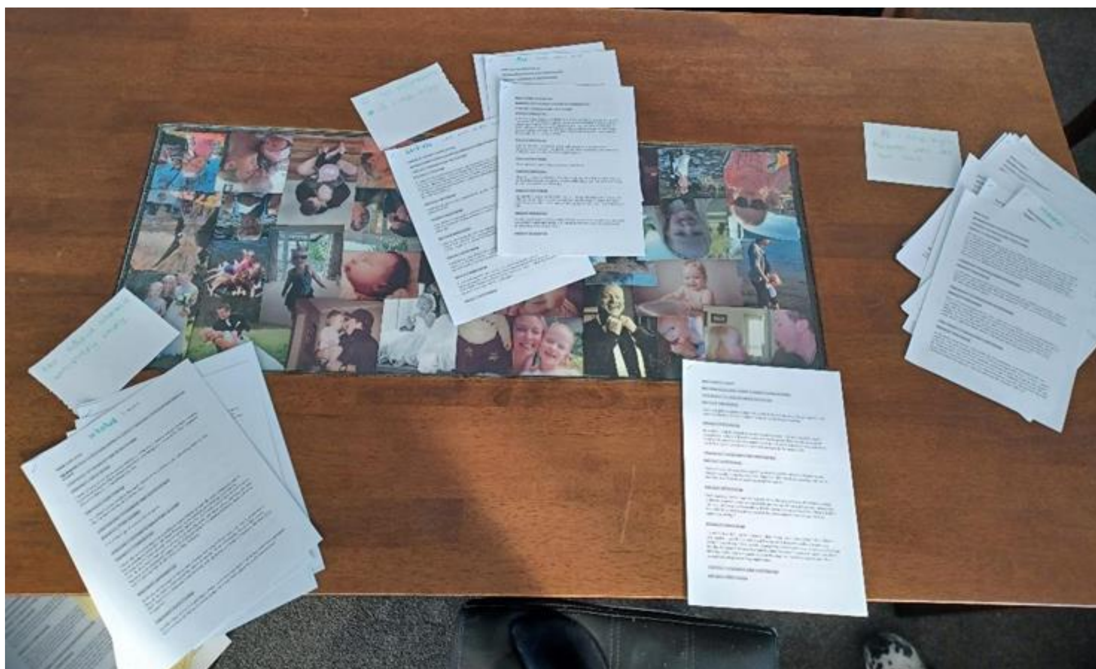
Note: The Transcriber should retain a copy of this form

Appendix K: Manual data analysis examples

A3 demonstrating written brainstorming of codes/initial themes that align with Pū anchor.



Initial themes printed and organised according to anchors



Close up photo of sorted themes against anchors. This photograph also demonstrates consideration of te reo Māori naming of themes.