Dean Cowles
Student ID: 1136366

# Strategies to improve Māori health outcomes, in private surgical settings, by understanding the perceptions and experiences of Māori nurses.

Year of lodgement: 2024
Faculty: Health and Environmental Sciences
School/Department: Health Sciences

A research component submitted to Auckland University of Technology in partial fulfilment of the requirements for the degree of Master of Health Science

# Abstract

In Aotearoa New Zealand, a disconcerting decline in Māori health outcomes persists, echoing historical roots dating back to the early days of colonisation. This enduring decline manifests in a stark life expectancy discrepancy between Māori and non-Māori. The WAI 2575 Health Services and Outcomes Kaupapa Inquiry underscored the widening health disparities over a quarter-century, revealing alarming rates of disease incidence for Māori. Although much research has occurred in the public sector to explore this disproportionate burden, little is known about Māori patient and whānau (family and extended family) outcomes within the private surgical environment. This study seeks to address this gap by delving into the perceptions and experiences of Māori nurses who work in private surgical settings, aiming to develop strategies to enhance Māori health outcomes within the private health sector. It strives to answer the following research question: How can the current experiences and perceptions of Māori nurses expose and reshape future realities for Māori patients and whānau when engaging in private surgical services?

This thesis adopts a research design grounded in kaupapa Māori methodology, employing a qualitative approach alongside autoethnography. The study leverages critical theory to unravel the intricacies and lived experiences of colonialism within the Māori experience of private surgical care. Te Ao Māori (Māori worldview) and mātauranga Māori (traditional Māori knowledge) permeate the various stages of the research process, including project consultation, autoethnography, researcher reflexivity, recruitment, interviews, data collection, analysis, and dissemination of findings.

In the autoethnography segment, insights from a practice-focused journal are utilised and analysed through Gibbs' reflective cycle and highlights the nuanced intersections of personal and professional aspects along the cultural identity continuum.

The qualitative phase involves interviewing Māori nurses in the private surgical setting. This research employs reflexive thematic analysis to interpret semi-structured interview data within the framework of kaupapa Māori research. The findings emphasise the value of Māori nurses, the need for collaboration, and enhanced education to improve cultural awareness.

The discussion highlights the transformative potential of incorporating Māori values into private healthcare practices. The recommendations advocate for comprehensive solutions, urging private healthcare organisations to prioritise cultural safety education, authentic collaboration, and policy reforms. The implementation of Māori mentorship programs, targeted recruitment strategies, and whakapapa leadership principles is proposed to cultivate a culturally responsive healthcare workforce and improve patient experiences in private surgical settings. Additionally, integrating co-design, mahitahi (kaupapa Māori initiative approach), and the Critical Tiriti Analysis framework into private healthcare initiatives is deemed crucial for promoting culturally responsive and equitable care for Māori.

In conclusion, this research provides a comprehensive examination of Māori nursing experiences in private surgical healthcare services, highlighting the profound impact of historical and contemporary factors. The study reveals how these elements contribute to racism and discrimination, hindering cultural health literacy and relationships between Māori patients/whānau and healthcare professionals. Despite these challenges, the research demonstrates the importance of understanding historical complexities for informed progress and advocates for ongoing research.

# Acknowledgements

Firstly, I would like to express my sincere gratitude to my research supervisors, Professor Jacquie Kidd and Doctor Jan Dewar – Ngā mihi me te aroha nui! Your expertise, knowledge, mana and tautoko throughout my thesis journey has been instrumental. The academic work you have both carried out regarding Māori advancement has been inspirational. This has shone through in the guidance you have provided in the development of my own research journey – Thank you!

Secondly, thank you to Grant Berghan and Tania Hodges for the initial guidance you provided in planning the direction of this research. The advice you both gave me about grounding myself in Te Ao Māori and embracing Māori ways of 'knowing', 'being' and 'doing' scaffolded the structure of my approach to the research process. Your insights and commitment to Māori clinical leadership is remarkable. Thank you for continuing to advance hauora Māori in all that you do.

Thirdly, to the participants of this study – Ngā mihi nui ki a koutou. Thank you for sharing your stories and narratives. It was humbling to see the shared experiences between us that we encounter within our nursing careers. The work that you do as Māori nurses needs to be acknowledged and celebrated. Without you, we would not see such high standards of cultural safety, clinical care and advocacy for Māori patients and whānau. You are all assets to your organisations, and are shaping the way forward for future Māori nurses.

Additionally, I would like to acknowledge the organisation that I work for. Thank you for funding my postgraduate study and committing to my professional development. I have always appreciated the support you have provided, and the opportunities you have given me to drive Māori-specific initiatives within our organisation. More specifically, thank you to Victoria Aliprantis and Pippin Morrison. You have both provided me with avenues and opportunities to contribute aspects of my research into our organisational processes – Ngā mihi maioha.

To my partner, Rhys – thank you for the support and encouragement you have provided throughout my research journey. Thank you for allowing me to 'vent' and debrief about the frustrations and achievements of this study's process – Arohanui ki a koe.

Finally, to my whānau, hapū, iwi and tūpuna – Mai te au i te whānau. I am a reflection of you. Thank you for strengthening the mana of our people, and reinforcing my wairua with the armour needed to carry out this research project.

# Mihimihi

E ngā mana
E ngā waka
E ngā reo
E rau rangatira mā
Tēnā koutou, tēnā koutou, tēnā tātou katoa

Ko Ranginui kei runga
Ko Papatūānuku kei raro
Ko ngā tangata kei waenganui
Tihei mauri ora!
E te Atua – Tēnā koe
E ngā mate – Haere, haere, haere atu rā
Ki a tatou te hunga ora
Ko mana te maunga
Ko aroha te moana
Ko whānau te waka
Ko au e tū atu nei
No reira
Tēnā koutou

Ko Pūtauaki te maunga
Ko Rangitaiki te awa
Ko Mataatua te waka
Ko Ngāti Awa te iwi
Ko Te Patuwai te hapū
Ko Tamatea ki te huatahi te marae
Ko Nadia Haua rāua ko Steffan Haua ōku mātua
Ko Dean Cowles tōku ingoa

Tēnā koutou, tēnā koutou, tēnā tātou katoa

# Table of Contents

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 (unless it is clearly stated, and referenced, along with the purpose of use), 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.

# 1 Chapter One: Introduction

## 1.1 Background and Overview

In Aotearoa New Zealand, the concerning decline in Māori health outcomes persists, rooted in historical factors dating back to the early days of colonisation. This decline has led to a noticeable discrepancy in life expectancy between Māori and non-Māori, as reported by the New Zealand Ministry of Health (Ministry of Health [MOH], 2022). The WAI 2575 Health Services and Outcomes Kaupapa Inquiry highlighted growing health disparities over a 25-year period, revealing alarming rates of cardiovascular disease and asthma-related hospital admissions for Māori (Waitangi Tribunal, 2019). Furthermore, the COVID-19 pandemic accentuated disparities, with Māori having the lowest vaccination rates during the height of the crisis (MOH, 2022), particularly in socioeconomically deprived areas.

Improving health outcomes in private surgical settings is crucial for addressing disparities faced by Māori patients, who access private hospitals through various means such as health insurance, private payments, charitable trusts, public sector funding, and the Accident Compensation Corporation (ACC). Despite a publicly funded health system in Aotearoa New Zealand, disparities remain, especially in accessing timely surgical treatments (Chalmers, 2020) that are culturally safe for Māori. In the context of breast cancer treatment, data shows that delays for surgical treatment are shorter in private hospitals compared to public ones (Seneviratne et al., 2015). However, Māori women are underrepresented in private surgical treatments, with only 8.1% compared to 32.5% of New Zealand European women (Seneviratne et al., 2015). Due to the increased number of publicly funded surgical lists and ACC contracts into the private sector, to ‘lighten the load’ in public hospitals, more Māori are entering this sector. However, cultural awareness and Māori workforce initiatives are questionable in the context of ensuring cultural safety for future Māori engaging in private surgical care.

Māori nurses, who represent just 8% of the nursing workforce in Aotearoa New Zealand despite constituting 17% of the population (Chalmers, 2020), bring significant value to the private surgical setting by enhancing cultural safety and improving patient outcomes. Their presence helps bridge the cultural gap between healthcare providers and Māori patients, fostering a more inclusive and respectful environment. This cultural alignment is crucial for ensuring that Māori patients feel understood and respected, which can lead to better communication, increased trust, and more effective care. To meet the Ministry of Health's equity standards, where the Māori nursing workforce reflects the Māori population, it is imperative to implement stronger policies and make deliberate investments aimed at increasing Māori representation in nursing (Waitangi Tribunal, 2019). The exact number of Māori nurses working in private surgical settings remains unknown, highlighting a critical gap in our health system's data collection and accountability. To address this, it is essential that we begin systematically gathering and analysing this information. Doing so will enable us to better understand and support the Māori nursing workforce in these environments. The Ngā Paerewa Health and Disability Services Standard could serve as a valuable framework to facilitate this data collection, ensuring that we uphold equitable practices and improve healthcare outcomes for Māori in private surgical settings.

This study aims to develop strategies to improve Māori health outcomes in private surgical settings, by understanding the perceptions and experiences of Māori nurses. It strives to explore Māori health outcomes, investigating causation, effects, and developing a baseline of knowledge to inform further research for enhancing holistic health. The literature review chapter of this thesis offers a critique of relevant studies within the themes of racism and discrimination, cultural health literacy, relationship building, and policy and legislation aligning with Crown ideologies. The synthesis of information within these themes ensures the validity and trustworthiness of the review findings, even in the limited research on private sector strategies for improving Māori health outcomes in Aotearoa New Zealand.

Chapter three brings a reflexive lens to the exploration of my own lived experiences and introduces the art of autoethnography (Ellis et al., 2011; Anderson, 2006). In this chapter I both write about and engage in autoethnographical research. The chapter discusses the value of autoethnography and its connection to kaupapa Māori (Māori approach) theory, addressing researcher positionality, data collection, analysis methods, and ethical considerations. Utilising this methodology, and applying the Gibbs' reflective cycle, I delve into my cultural journey, intertwining personal and professional identity reconstruction.

The subsequent chapter describes kaupapa Māori as a research methodology, intricately woven throughout this project. It navigates the complexities of critical theory and colonialism, demonstrating how kaupapa Māori methodology shapes the project from consultation to data dissemination. This chapter explores the process of applying kaupapa Māori methodology to the recruitment and interviewing of Māori nurses within the private surgical setting in Aotearoa New Zealand. Further, reflexive thematic analysis is applied to the dataset where three core themes were generated: (1) He kai kei aku ringa (there is food at the end of my hands) – This theme relates to the attributes that Māori nurses bring to the health space; (2) He waka eke noa (a canoe in which we are all in, with no exceptions) – This signifies a collective journey; (3) Whaiwhia te kete mātauranga (fill the basket with knowledge) – This refers to the need for developing and delivering education initiatives to enhance cultural awareness, competency and safety.

Moving into the findings chapter marks a pivotal point, delving into the experiences of the participants, examining and dissecting the themes. This chapter functions as a guide which uncovers the commonalities woven through the diverse set of gathered data. These themes serve as the essence of the investigation, offering a framework to organise and grasp the many facets of the topic. The findings enable the formulation of conclusions, establish connections, and provide interpretations, all of which are integral in contributing to the broader knowledge base regarding the development of strategies to improve Māori health outcomes in the private surgical setting.

Finally, the discussion chapter addresses the research question: How can the current experiences and perceptions of Māori nurses expose and reshape future realities for Māori patients and whānau when engaging in private surgical services? It explores the intricate relationship between Māori values and nursing practice in private healthcare settings, emphasising the impact of cultural values on care delivery. It proposes a transformative approach, advocating for a comprehensive overhaul of healthcare education, workforce development, leadership models, collaborative processes, and the application of the Critical Tiriti Analysis framework to ensure cultural safety. It synthesises the interconnected themes, revealing critical aspects of Māori experiences in private surgical healthcare. Despite historical and contemporary challenges, it emphasises the positive aspect of understanding historical complexities for informed future progress, underscoring the ongoing necessity for research to address persisting disparities for Māori.

# 2 Chapter Two: Literature Review

## 2.1 Introduction

Within Aotearoa New Zealand, the state of Māori health continues to decline with contributing factors dating back to the early days of colonisation. This decline results in Māori having a lower life expectancy than non-Māori (MOH, 2022). Over a 25-year period, Māori health trends were monitored by the New Zealand Ministry of Health (MOH), resulting in a report to the WAI 2575 Health Services and Outcomes Kaupapa Inquiry (Waitangi Tribunal, 2019). The report identified growth in disparities between Māori and non-Māori. Along with continued deprivation of the determinants of health, Māori hospital admissions for cardiovascular disease were almost double that of non-Māori aged above 35 years (MOH, 2019). Hospital admissions relating to asthma were also alarmingly high for Māori patients between 5-34 years (MOH, 2019). When we consider treatment and engagement in preventative measures, the COVID-19 pandemic highlighted concerns about Māori vaccination rates. Māori had the lowest vaccination rate of all groups during the height of the pandemic in Aotearoa New Zealand (MOH, 2022). A report by the New Zealand Director-General of Health stated that vaccination rates were lowest within socioeconomically deprived areas of the country. This points to a direct correlation between poor determinants of health and health inequity for Māori.

The overall health status of Māori must be further explored and analysed to determine causation, effects, and to develop a baseline of knowledge to inform further research opportunities to enhance the overall hauora (holistic health) for Māori. This chapter establishes the purpose for a literature review and provides a succinct critique of relevant studies associated with racism and discrimination, cultural health literacy and relationship building, and policy and legislation aligning with Crown ideologies. The studies reviewed have been categorised within these three themes to provide a synthesis of the information to ensure validity and trustworthiness of the review findings. Although there is limited research on strategies to improve Māori health outcomes within the private sector in Aotearoa New Zealand, the analysis of studies within this review is of value as it provides a general baseline and identifies the need for further research within the private surgical setting. An opportunity emerges for developing a body of knowledge to initiate enhanced practice in delivering Māori-centric services in private hospital settings.

## 2.2 Background and Search Strategy

Reviewing past and current literature enables the researcher to assess and map out information and research about a particular topic. It provides an avenue to understand what has been explored and accomplished in the past (Grant & Booth, 2009). These are the beginning steps of building on this research base to develop knowledge in an area of interest (Snyder, 2019).

During the early stages of assessing literature for this review, I drew on key themes that had been identified during literature reviews from my postgraduate assignments which were based around racism, uneven access to determinants of health, and Crown principles being embedded in health mandates. At that time, it had become clear that little research had been done to explore Māori health inequities and Māori nurse experiences within the private surgical setting in Aotearoa New Zealand. Therefore, following a scan for newly published papers, for this review I focused on those themes within the broader setting of the New Zealand health system. This is aligned with the process of conducting a narrative synthesis whereby the aim was to unravel overarching stories within the evidence being reviewed (Madden et al., 2018). Further, it was important to develop an inclusion and exclusion criteria that guided the search for relevant research. As shown in Table 1, the inclusion and exclusion criteria were used to determine eligibility of studies used for this review.

**Table 1**

*Inclusion and Exclusion Criteria for determining literature relevance and eligibility for this review*

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| • Topics relating to racism, uneven access to the determinants of health, Crown ideologies, health policy and legislation<br>• Peer-reviewed journal articles<br>• Grey literature published by reputable organisations and government publications<br>• Published between 2011-2022<br>• Written in English<br>• Qualitative research<br>• Studies conducted in New Zealand and internationally<br>• Inclusive of all genders, all ages, and all levels of health (who have had healthcare experiences)<br>• Indigenous population groups | • Studies not directly related to the topic of this literature review<br>• Unpublished studies or grey literature<br>• Works that are not considered to be scholarly or rigorous (blogs, news articles, webpages) for literature reviews<br>• Studies published prior to 2011<br>• Quantitative research |

Additional keywords and phrases were derived from the planned themes and searched. These were Māori health, Māori health and well-being, Māori nurses, Indigenous, racist, discriminate, prejudice, injustice, inequity, colonisation, culture, tikanga, Māori protocols, mātauranga Māori, Māori worldview, whanaungatanga, nursing perspective, cultural competency, Te Tiriti o Waitangi, Critical Tiriti Analysis, WAI 2575, Māori health policy, and Māori health guidelines. The databases used to search these keywords and phrases were CINAHL Complete (via EBSCO), ClinicalKey, and Cochrane Library (via OVID). The keyword search was adapted for each database and the results were further refined to search for academic journals published between the years 2011-2022. With constant emergence of new discoveries, methodologies, and theories, sourcing academic journal articles during this timeframe better reflects the current state of knowledge. They tend to address the changing demographics, current trends, issues, and concerns more effectively, containing the most up-to-date information, methodologies, and data that are directly applicable to specific research topics relating to historic issues regarding Māori health advancement, or lack thereof. It is important to note that when searching for studies about racism, I did not want to limit the search to New Zealand studies because a global comparison of racism and colonisation within Indigenous communities was needed. It was evident that similar themes had emerged from overseas research where colonisation had occurred. When conducting the keyword and phrase search, I identified specific articles by reading the abstracts first to determine relevance. Here, I could determine whether-or-not the predetermined themes were present. Table 2 highlights the number of sources found, screened, and included for the analysis. From here, Table 3 demonstrates the analysis which included categorising the type of study, abstract summary, key findings, location of study, and key themes. In total, eight studies were deemed useful and appropriate to proceed with this review whereby overlapping themes were evident.

**Table 2**

*Literature Screening and Eligibility Process for sourcing relevant studies*

| Literature Screening and Eligibility Process | | | | | |
|---|---|---|---|---|---|
| Database | Records identified | Abstracts screened against inclusion & exclusion criteria | Full text articles assessed for eligibility | Studies included in data analysis | Studies excluded based on relevancy |

| | | | | | |
|---|---|---|---|---|---|
| CINAHL Complete (via EBSCO | (n = 281) | (n = 45) | (n = 10) | (n = 6) | (n = 2) |
| Clinical Key | (n = 48) | (n = 11) | (n = 6) | (n = 2) | |
| Cochrane Library (via OVID) | (n = 6) | (n = 2) | (n = 1) | (n = 0) | |

**Table 3**

*Characteristics of Eligible Articles retrieved and used for this Literature Review*

| Characteristics of Eligible Articles used for this Literature Review | | | | |
|---|---|---|---|---|
| Article | Abstract Summary | Research Design | Location | Key Themes |
| Came, H., Kidd, J., & Goza, T. (2020a). A critical Tiriti analysis of the New Zealand Cancer Control Strategy. *Journal of Cancer Policy, 23*. https://doi.org/10.1016/j.jcpo.2019.100210 | The study emphasises the significance of Te Tiriti o Waitangi in New Zealand's health policy, attributing breaches to the enduring health gaps between Māori and non-Māori, specifically in cancer rates. It evaluates the existing Cancer Control Strategy by examining its alignment with Te Tiriti articles and highlights the need to integrate these into practice to address health disparities effectively. | Critical Tiriti Analysis | Aotearoa New Zealand | Te Tiriti o Waitangi Misalignment: The NZCCS doesn't align well with Te Tiriti o Waitangi, impacting health sector design, funding decisions, service delivery, and workforce development.<br>Māori-Centric Health Policy: Normalising Te Ao Māori is essential for achieving health equity and self-determination health policy.<br>Tikanga-Led Policy Development: Further development of policies guided by traditional healing and customary practices is crucial, following the Waitangi Tribunal's recommendations. |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
|  |  |  |  | Ineffective Systems for Māori: Current Crown agency systems aren't effective in creating beneficial policies for Māori communities.<br>External Review Importance: Independent external review is necessary to strengthen health policy for better inclusivity and effectiveness.<br>Global Relevance: Lessons from New Zealand's experience can inform global efforts in addressing Indigenous health disparities and decolonising health systems.<br>Healing and Restoration: The cancer control plan should actively work to address past harm caused by health |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
| | | | | policies, incorporating spiritual and cultural elements. |
| Came, H., O'Sullivan, D., & McCreanor, T. (2020b). Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy. *Ethnicities, 20*(3), 434-456. https://doi.org/10.1177/1468796819896466 | The article explores the historical background of Te Tiriti o Waitangi and the Treaty of Waitangi, and their importance for Māori health, highlighting conflicting interpretations. It introduces critical Tiriti analysis as a tool to assess health policies in line with the articles of Te Tiriti, exploring concerns within the 2001 New Zealand Primary Health Care Strategy. | Critical Tiriti Analysis | Aotearoa New Zealand | CTA for Transparent Policy Review: CTA provides a transparent process for assessing policies regarding Te Tiriti o Waitangi, highlighting Māori involvement and acknowledging Māori authority in health policy.<br>Spiritual Aspect in Health Policy: CTA highlights the importance of engaging with spirituality for holistic Māori well-being, an often overlooked aspect in health policy.<br>Broad Applicability of CTA: Beyond health, CTA's five-phase approach could benefit various policy areas, such as responses to historic abuse in state care |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
| | | | | and criminal justice reviews, significantly affecting Māori.<br>Global Relevance and Indigenous Rights: CTA's potential extends to contexts where Indigenous values need reconciliation.<br>Advocacy for Adoption: Encouragement for widespread adoption, adaptation, and debates around the CTA framework as a tool for advancing social equity, sustainability, and justice. |
| Graham, R., & Masters-Awatere, B. (2020). Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research. *Australian & New Zealand Journal of Public Health,* | The study sought insights from Māori patients and their whānau regarding their encounters in New Zealand's public health system. Examining 14 papers, it revealed challenges (system | Qualitative Meta synthesis | Aotearoa New Zealand | Perceived Hostility of Public Health System:<br>Many Māori feel the existing public health system is unwelcoming and isolating. |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
| *44*(3), 193-200. https://doi.org/10.1111/1753-6405.12971 | structures, staff interactions, practical aspects) and supportive factors (whānau assistance) influencing healthcare experiences. Many Māori perceive the system as unfriendly, with whānau support serving as a remedy despite its associated burdens. The findings underscore the need for public health providers to create a culturally sensitive and supportive healthcare environment for Māori. | | | Few supportive interactions with individual practitioners stand out but are not the norm.<br>Historical Context and Collective Memory:<br>Māori responses within today's context stem from decades of poor treatment, discrimination, and condescending behaviour.<br>Contemporary experiences need to be understood in the context of past mistreatment and prejudice.<br>Integration of Tikanga Māori in Healthcare:<br>Efforts should focus on supporting and incorporating Tikanga Māori practices within mainstream healthcare systems. |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
|  |  |  |  | Understanding Māori Health Practices and Trauma:<br>Healthcare settings and staff should acknowledge diverse Māori health practices.<br>Awareness of historical and intergenerational trauma is crucial in present-day interactions.<br><br>Improving Healthcare for Māori:<br>The analysis emphasises the necessity for significant improvements in the current public health system.<br>There's a need to ensure consistent, positive, and culturally sensitive interactions that align with Te Ao Māori. |
| Hunter, K., & Cook, C. (2020). Indigenous nurses' practice realities of cultural safety and socioethical nursing. *Nursing Ethics,* | The article focuses on integrating cultural safety into healthcare. It assesses Woods' theoretical | Qualitative Indigenous | Aotearoa New Zealand | Cultural needs overshadowed by clinical care prioritisation: |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
| *27*(6), 1472-1483. https://doi.org/10.1177/0969733020940376 | framework in a socioethical model through a study involving 12 Māori nurses in New Zealand. It explains that while clinical care often overshadows cultural needs, recognising and addressing these needs is crucial. Non-Indigenous nurses need to critically reflect on broader equity issues impacting Indigenous healthcare engagement. The study emphasises the significance of retaining Indigenous nurses for their advocacy and cultural alignment, while leadership plays a key role in preserving culturally safe care in healthcare settings. The findings stress the need for nurses to reflexively | Narrative Inquiry | | Māori cultural needs, crucial for care, were often side-lined due to the emphasis on clinical aspects.<br>Critical reflection on broader equity issues for ethical non-Indigenous care: Non-Indigenous nurses need to critically examine broader equity issues influencing Māori disengagement from healthcare for ethical care provision.<br>Importance of retaining Indigenous nurses: Indigenous nurses' retention is vital due to their advocacy and cultural alignment, contributing to positive healthcare outcomes for Māori.<br>Role of committed leadership in preserving culturally safe care: |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
| | engage with an ethic of care and social justice dimensions to ensure culturally safe care for Indigenous groups. This framework provides a vital perspective for nurses to evaluate their practices and systemic factors affecting culturally safe care for any Indigenous population. | | | Strong leadership commitment safeguards culturally safe care, preventing its erosion due to workplace efficiencies or other factors. |
| Huria, T., Cuddy, J., Lacey, C., & Pitama, S. (2014). Working with racism: A qualitative study of the perspectives of Māori (Indigenous peoples of Aotearoa New Zealand) Registered Nurses on a global phenomenon. *Journal of Transcultural Nursing, 25*(4), 364-372. https://doi.org/10.1177/1043659614523991 | The article examines how racism affects Māori registered nurses in New Zealand's healthcare system. Analysing narratives from 15 Māori nurses, the study reveals racism across institutional, interpersonal, and internalised levels, leading to their marginalisation and | Qualitative Kaupapa Māori Methodology | Canada (Primary analysis)<br>Aotearoa New Zealand (Secondary Analysis) | Racism as a divisive term: Racism often triggers strong denial from the majority while being a lived reality for the minority, hindering open discussions.<br>Impact of racism in nursing: Research reveals that racism within nursing creates a demeaning environment, perpetuating discrimination and contributing to the |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
| | undervaluation despite being overworked. Māori nurses feel their cultural competencies aren't acknowledged alongside their clinical skills. Addressing racism at all levels is crucial in supporting Indigenous nurses and developing dual cultural-clinical competencies within healthcare environments, essential for better recruitment, training, and practice for Māori nurses in New Zealand and other Indigenous communities worldwide. | | | departure of Indigenous nurses from the profession.<br>Three levels of racism: Nurses face potential exposure to racism at different levels, emphasising the collective responsibility of nurses and institutions to take action and develop strategies to eradicate racism.<br>Collective responsibility for positive change: Addressing racism collectively will lead to a stronger Indigenous nursing workforce and ultimately enhance health outcomes for Indigenous populations. |
| Kidd, J., Black, S., Peni, T., & Blundell, R. (2018). Cultural health literacy: the experiences of Māori in palliative care. | The article explores health literacy beyond patient abilities, considering the skills of health | Qualitative Kaupapa | Aotearoa New Zealand | Factors influencing information utilisation in palliative care: |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
| *Global Health Promotion, 25*(4), 15-23. https://doi.org/10.1177/1757975918764111 | professionals and resource accessibility. It specifically investigates Māori health literacy and cultural health literacy in a palliative care context in Aotearoa New Zealand. Through interviews with patients, families, key informants, and health professionals, a thematic analysis was conducted using a general inductive approach. The study's credibility was ensured through analysis validation among the research team and confirmation of findings in meetings with the involved communities. | Māori Methodology | | Health professionals' willingness and ability to conduct clear and timely discussions regarding the transition from active treatment to palliative care were crucial for patients and families to understand care options and illness trajectories.<br>Importance of cultural health literacy within organisations:<br>Cultural health literacy within healthcare settings was essential to transmit information in culturally acceptable and understandable ways.<br>Compatibility of palliative care services with the Māori worldview influenced participants' decisions; discrepancies in care aims sometimes led to reluctance or delayed access to services. |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
| | | | | Development of complex health literacy practices:<br>Patients and families devised intricate health literacy strategies to navigate cultural and communication barriers within the palliative care environment.<br><br>Urgent need for addressing cultural health literacy:<br>Emphasises the critical need to address cultural health literacy to ensure equitable access to palliative care in Aotearoa New Zealand. |
| Wylie, L., & McConkey, S. (2019). Insiders' insight: Discrimination against Indigenous peoples through the eyes of health care professionals. *Journal of Racial and Ethnic Health Disparities, 6*(1), 37-45. https://doi.org/10.1007/s40615-018-0495-9 | Discrimination within the healthcare system significantly impacts the health and wellbeing of Indigenous communities, contributing to health disparities. This research investigates | Qualitative Methodology | Ontario, Canada | Discrimination Impact on Indigenous Healthcare:<br>Discriminatory attitudes among healthcare staff pose challenges for Indigenous patients, hindering trust-building and care quality. |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
|  | healthcare providers' and decision-makers' perspectives on challenges faced by Indigenous patients and families accessing health services in southern Ontario. The findings underscore the need to address deep-rooted biases and discrimination in healthcare beyond creating a welcoming environment. Transforming healthcare norms shaped by discriminatory attitudes is crucial to ensure equitable services for Indigenous populations, demanding a fundamental shift in healthcare providers' attitudes, knowledge, and accountability within healthcare organisations as part |  |  | Media-fuelled stereotypes shape provider biases, creating unwelcoming environments and compromising treatment for Indigenous populations.<br>Access Barriers and Lack of Understanding:<br>Discrimination leads to late diagnoses, worsening health outcomes for Indigenous people, highlighting systemic barriers in Canada's healthcare.<br>Widespread misunderstanding among care providers emphasises the need to address discrimination and negative stereotypes.<br>Systemic Changes for Equitable Healthcare:<br>Health organisations must combat biases through respectful engagements, |

Characteristics of Eligible Articles used for this Literature Review

| Article | Abstract Summary | Research Design | Location | Key Themes |
|---|---|---|---|---|
|  | of a comprehensive quality improvement strategy. |  |  | promoting cultural safety, and reshaping narratives with Indigenous patients. Achieving a welcoming healthcare environment requires transforming provider attitudes and institutional culture, necessitating ongoing training for equity, aligning with recommendations from the Truth and Reconciliation Commission. |

## 2.3 Theme 1: Racism and Discrimination

Globally, Indigenous health has been represented as a burden on health systems by governmental bodies, policymakers, or individuals who focus on financial aspects associated with addressing Indigenous health disparities. Narratives of Indigenous communities have reflected the reality that racism and discriminatory behaviours are prevalent experiences of minority groups. One international study, conducted in Canada by Wylie and McConkey (2018) explains that healthcare providers are often ignorant about the complexities associated with the social determinants of health within Indigenous population groups. Where colonialist invasion has occurred, there appears to be little regard for historical influences associated with land confiscations, the suppression of autonomy, and identity degradation (Kidd et al., 2018). These colonialist effects have contributed to systemic challenges such as poverty, low-income, housing overcrowding, and low levels of education. Wylie and McConkey (2018) explain that when these factors are ignored, healthcare workers assume that such groups simply do not look after themselves. Although this study was not conducted in Aotearoa New Zealand, the core themes have been mirrored in a recent study completed in Aotearoa New Zealand. Hunter and Cook (2020) explored similar themes associated with stereotyping and discriminatory attitudes against Māori. Within this study, the authors drew upon some confronting examples that highlight these behaviours within the New Zealand primary healthcare setting. Hunter and Cook explain that non-Māori nurses often avoid visiting Māori clients in their homes due to poor housing conditions and overcrowding. Unfortunately, the stigma associated with nurses' perception assumes substance abuse, violence, and unrestrained behaviours (Hunter & Cook, 2020). Graham and Masters-Awatere (2020) concur that individuals and whānau consistently face adverse perceptions and attitudes from healthcare practitioners. Māori often encounter hostile and interrogatory practices, marked by dubiousness and suspicion when seeking healthcare (Graham & Masters-Awatere, 2020). These behaviours serve as the foundation of interpersonal racism, wherein healthcare professionals exhibit societal prejudice and discriminatory bias (Theunissen, 2011). Consequently, Māori find themselves unfairly held accountable for their health disparities, experiencing a sense of control, undermining, and domination by Western ideologies (Kidd et al., 2018), highlighting a lack of consideration for Māori diversity and culture in the healthcare domain. This has resulted in a pervasive mistrust in the health system, leading to Māori hesitancy in accessing healthcare services.

In addition to bias and stereotyping, these attitudes contribute to misdiagnoses, delayed diagnoses, and delayed referrals for Indigenous populations (Wylie & McConkey, 2018). As a result, Māori exhibit disproportionately high incidence, morbidity, and mortality rates for life-threatening conditions such as cancer, cardiovascular diseases, and respiratory illnesses (Kidd et al., 2018). Research indicates a one-month delay in intervention for Māori diagnosed with colon cancer, underscoring disparities in timely healthcare delivery (Theunissen, 2011). Furthermore, when chemotherapy is necessary, Māori are less likely to receive this treatment compared to non-Māori (Theunissen, 2011), exemplifying differential treatment within a healthcare system that hinders prompt service provision for Māori. This reflects institutional racism, revealing systemic disparities within the healthcare infrastructure. These issues are emblematic of the enduring effects of colonisation (Theunissen, 2011), as the design of the New Zealand health system reinforces the dominance of biomedical practices while minimising and disregarding cultural and spiritual dimensions of health (Graham & Masters-Awatere, 2020).

As understanding of the effects of racism and discrimination toward Māori grows by exploring patient/whānau perspectives and experiences, academics are examining similar perspectives of Māori nurses. Huria et al. (2014) aimed to explore the impact that racism had on this group within the New Zealand health system. As part of a secondary analysis from a larger project, they sought to discover meaning within the narratives of 15 Māori nurses. Much like the narratives in Māori-patient research, both interpersonal and institutional racism are embedded in the nurses' stories. In fact, the authors introduced a third category: Internalised racism, whereby the nurses have grown to accept acts of racism and discrimination towards them (Huria et al., 2014). However, internalised racism extends beyond mere acceptance. It can lead individuals to perpetuate interpersonal and systemic racism within their own culture. This phenomenon involves internalising negative stereotypes and biases, which may result in either believing those stereotypes and consequently feeling unworthy or deflecting these beliefs through symbolic acts of aggression against others (Jones, 2000). In a qualitative Māori-centred narrative inquiry, Hunter and Cook (2020) explain that this aspect of racism has disempowered Māori nurses to advocate for the cultural needs of Māori patients and whānau due to the continuous undermining of their Māori-centric clinical abilities. Their experiences elucidate the challenging dynamics they face – being automatically designated as the 'cultural expert' while concurrently needing to justify their roles, particularly if their positions are focused on Māori healthcare (Huria et al., 2014). These nurses encounter isolation, covertly racist comments, and a need to constantly validate their expertise, all of which serve to remind them of their minority status within the workplace (Hunter & Cook, 2020). Further, dismissive remarks about significant aspects of Māori identity contribute to a sense of undervaluation. This is an example of interpersonal racism whereby the end result leads to internalised racism. This contributes to further marginalisation of Māori nurses. Therefore, often impacting on their ability to provide Māori-centric care. Although these are generalisations based on the personal accounts of Māori nurses within the chosen studies for this literature review, it is important to recognise that these may not be shared experiences for all Māori who work within the nursing field. It is vital to be mindful that the upbringings of Māori may determine differing lived experiences, perceptions and levels of resilience. While both studies successfully explored the narratives of Māori nurses, a key limitation for this review is that the participants were not from the private sector. One participant in Hunter and Cook's (2020) study explained that Māori health services in the community and primary care settings are well-established and well-researched. This highlights the need for further studies to occur in under-researched areas to ensure Māori-centric care and intervention can reach all corners of the health system. Therefore, this research project will examine racism and discrimination in the private surgical setting with the purposes of developing strategies to move away from such practices whilst facilitating quality health outcomes for Māori.

## 2.4 Theme 2: Cultural Health Literacy and Relationship Building

In unpacking and exploring the underpinnings of racism and discrimination, Huria et al. (2014) recognised that non-Māori health professionals often lack knowledge and understanding about Māori worldviews and practices. Arguably, this could be due to 'tunnel-vision', ignorance, an innocent lack of exposure, or blatant racial prejudice. However, other studies assert the idea that health professionals and services must ensure cultural competence, from an ethical standpoint, as the foundation for providing appropriate care to Indigenous groups (Hunter & Cook, 2020). Along with supporting Māori nurses to provide Māori-centric care to Māori patients and whānau, the health system in Aotearoa New Zealand must be committed to improving the cultural health literacy of all health practitioners to ensure culturally tailored health services are delivered to Māori whilst battling racism and discrimination.

In a kaupapa Māori research study, the researchers explored cultural health literacy in the palliative care setting by interviewing patients, whānau and key-informants. They noted that health literacy was usually understood to be a process of one's ability to receive and understand health information with the result of making informed health decisions (Kidd et al., 2018). However, they explained that this process must include the way in which health professionals and organisations provide health messages to Māori patients and whānau that are grounded in Māori worldviews and tikanga (Māori system of customs and traditions) practices (Kidd et al., 2018). This is cultural health literacy. Other research has highlighted the challenges associated with inadequate incorporation of cultural considerations in the interactions between non-Māori healthcare practitioners and Māori patients and whānau. Trust-building practices by non-Māori practitioners have generally been found to be ineffective (Graham & Masters-Awatere, 2020), resulting in a lack of established or sustained rapport. Māori patients and staff have expressed concerns that practitioners often approach communication with Māori patients and whānau from a Western perspective, making their efforts either irrelevant or incomprehensible for whānau (Kidd et al., 2018). In specific contexts, such as cancer settings, it is unrealistic to expect Māori individuals to immediately engage in discussions about their diagnosis, treatment, or intervention during initial interactions with clinicians. In these situations, the concept of whanaungatanga (binding of relationships), emphasising the development of close connections, becomes crucial. Practitioners should prioritise displaying compassion, empathy, and authenticity in their behaviours and attitudes (Wilson et al., 2021). They must be responsive to patient values and concerns while actively advocating for cultural needs (Wilson et al., 2021). These elements serve as foundational components for establishing a secure environment conducive to sharing, relationship building, and fostering close connections. Kidd et al. (2018) found that this was not always evident in the palliative care space. There was little consideration for the emotional aspect around grief and loss, within the dialogue between the practitioner and patient/whānau, which made health information difficult to comprehend and therefore resulted in a negative experience. These sub-standard cultural health literacy practices often resulted in whānau avoidance of accessing health services and inequitable disease progression and outcomes (Kidd et al., 2018).

Huria et al. (2014) implied that there is a lack of institutional awareness about Māori worldviews and tikanga practice within some primary and secondary health organisations. Albeit there are minimal Māori nurses to drive such initiatives. On the other hand, interviews conducted by Hunter and Cook (2020) revealed that some organisations are well-equipped with culturally competent nurses. Participants expressed praise about non-Māori nurses carrying out tikanga practices around the appropriate use of linen for different areas of the body, facilitation of karakia (prayer) when death is imminent or occurring, and accessing Māori-health support systems (Hunter & Cook, 2020). Interestingly, these examples were from organisations where their Director of Nursing and Assistant Director were both Māori. This represents the need for an increase in Māori clinical leadership roles to develop and deliver cultural health literacy initiatives across the health sector. The studies by Huria et al. (2014) and Hunter and Cook (2020) have thoroughly examined important aspects of cultural health literacy which are relevant to this research project. However, further research is the private sector is required in order to reach all aspects of the New Zealand health system.

The study by Kidd et al. (2018) reflects trustworthiness and reliability due to its rigorous inductive thematic analysis. They have ensured validity by confirming the findings with the participants across five hui (large gathering). This is indicative of a thorough kaupapa Māori methodology which is relevant to this research project. Despite providing a thorough depiction of cultural health literacy and relationship-building, from the perspectives of Māori patients, whānau and key informants, the study was restricted to the palliative care setting and does not explore the private surgical environment. The evidence within these articles suggests appropriate strategies to improve cultural health literacy which have always been a necessity in achieving positive Māori health outcomes. However, the non-achievement of this goal is associated with the historical development of the health system.

## 2.5 Theme 3: Policy and Legislation Aligning with Crown Ideologies

In 1840, Te Tiriti o Waitangi (Māori text) and the Treaty of Waitangi (English text) were established to forge a sovereign relationship between the British Crown and Māori in Aotearoa New Zealand (Came et al., 2020a). Since their inception, the English text has significantly influenced public policy development, legislative precedence, and political discourse, resulting in adverse effects on the Māori population (Came et al., 2020b). Despite this dominance, it is crucial to recognise that the Māori text holds legal precedence over the English text, as stipulated in the legal doctrine of contra proferentem (Came et al., 2020a), making it the sole legitimate version. Historically and presently, there has been a widespread misconception that the Treaty of Waitangi is an exact translation of Te Tiriti o Waitangi. In reality, these are distinct documents with individual meanings and unique implications. When Te Tiriti o Waitangi was negotiated and signed, Māori anticipated retaining political authority and securing protection from the Crown (Came et al., 2020b). However, the Crown interpreted the agreement differently, asserting full sovereignty over Māori and their aspirations. The Crown's preference for the English text became evident as it took precedence in colonial projects. Subsequently, the discouragement of Māori language and culture ensued, notably through the enactment of the Native Schools Act and the Tohunga Suppression Act (Came et al., 2020b). Only in recent years have policy and legislation been thoroughly investigated through a Tiriti lens.

In 1975, the Royal Commission on Social Policy applied principles from the Treaty of Waitangi to formulate and implement the 'three P's' – participation, protection, and partnership – in the health sector (Came et al., 2020a). Nearly two decades later, the New Zealand Health and Disability Act embraced the 'three P's,' influenced by the earlier work (Came et al., 2020a), subsequently shaping additional policy initiatives. Over the years, the Waitangi Tribunal, investigating Treaty breaches, has found that Māori health disparities persist. A Waitangi Tribunal report, WAI 2575, highlighted health inequities, access challenges, racism, and discrimination, attributing them to Crown shortcomings and emphasising the influence of historical policies based on the English version of the Treaty of Waitangi. The WAI 2575 hearings acknowledged that Māori have not aligned with Western principles of protection, partnership, and participation, asserting that these concepts were foreign constructs developed through Western collaboration and have influenced public policy and health strategies (Came et al., 2020a). The endorsement of Western practices in mainstream services, as evidenced by practical applications, reflects institutional racism and the intricate socio-political landscape. In contrast, Māori focus on specific articles in the Māori text, emphasising their creation by and for Māori (Came et al., 2020a). These articles encompass kāwanatanga (governance), tino rangatiratanga (sovereignty), ōritetanga (citizenship/equity), and wairuatanga (spirituality), advocating for their direct application in clinical practice.

Further, Came et al. (2020b) conducted a retrospective Critical Tiriti Analysis (CTA) on the New Zealand Primary Healthcare Strategy. The aim of this evaluative tool was to guide further policy development to promote the elimination of Māori health inequities. From the CTA findings, Came et al. (2020b) found that the Primary Healthcare Strategy referred only to the English text, the Treaty of Waitangi, and alludes to the notion that Māori are a burden on the health system. Further, they recognise that kāwanatanga has not been upheld as Māori have not had any equitable governing input into the development of the policy. In a separate CTA on the New Zealand Cancer Control Strategy, carried out by Came et al. (2020a), it was revealed that this too lacked Māori input. However, there was Māori representation on its steering group. What's more, Came et al. (2020b) found that the Primary Healthcare Strategy was non-inclusive of Māori ideologies and equity. Therefore, reflecting an element of institutional racism. To mitigate this, Came et al. (2020b) recommended that all policies should be well-aligned with Te Tiriti o Waitangi and contemporary Māori health strategies such as He Korowai Oranga. The CTA on both strategies do not consider the spiritual aspect of Te Tiriti, wairuatanga.

Finally, both CTA studies provide appropriate recommendations, but the key message is that health policies should be revised to ensure Māori consultation and Māori worldviews. It is evident that CTA, as an evaluative tool, ensures that health services and organisations are monitored and held accountable. These articles provide a high-level analysis on policy development to positively impact the Māori population. One limitation of these studies in relation to this research is the need to carry out a CTA on policies from the perspective of the private sector. Despite this, there is clear evidence that demonstrates the complexities associated with reframing and redefining policies, legislation and guidelines that truly encompass the central components of Te Tiriti o Waitangi.

## 2.6 Conclusion

In conclusion, this chapter has reviewed the available literature to inform the direction of future research. Selected literature has been described and critiqued to expose the negative realities that Māori have faced since the early days of British colonisation. Its historical and current effects have contributed to socioeconomic deprivation, high morbidity and mortality rates, health inequities, and a forced Westernised way of living. Although the themes of racism and discrimination, cultural health literacy and relationship building, and policy and legislation aligning with Crown ideologies are separated for clarity and cohesion, there is a clear overlap in the correlations between each theme. Each theme is interrelated and connected through one core component: colonisation. The infrastructure of the overall health system has been built upon a Westernised foundation derived by poor policy and legislation development that has not favoured Māori. This can be viewed as an act of racial discrimination, institutionally, and also further contributing to interpersonal and internalised racism. All restrict the process of cultural health literacy and relationship building between Māori patients/whānau and health professionals. Even though this review emphasises negative aspects, the apparent realisations present a somewhat positive outcome. They suggest that gaining a thorough understanding of the historical and present complexities related to Māori health experiences can facilitate progress going forward. Therefore, further reinforcing the need for this research project.

# 3 Chapter Three: Autoethnography

## 3.1 Introduction

This reflexive chapter defines, explores and then utilises the art of autoethnography (Ellis et al., 2011; Anderson, 2006) to describe, analyse and appraise the complex realities that I have experienced throughout my cultural journey across my lifespan. The subjective accounts that I have portrayed throughout this chapter provide insight into personal and professional identity reconstruction and aims to elicit emotion and thought provocation for the reader. This chapter provides an exploration of the value of autoethnography as a methodology (Cooper & Lilyea, 2022), and its connection to kaupapa Māori theory in this project. I then discuss my researcher positionality, data collection and analysis methods, followed by identifying issues relating to rigour and ethics during autoethnographical work.

To ensure deep reflexivity, the first stage of the autoethnography sets the scene by presenting a preliminary or backgrounding autoethnography to explore 'self' within my own cultural journey. It is important to note that this introduces the intersections between my personal and professional identities. Drawing on the Gibbs' reflective framework (Paterson & Chapman, 2013; Ingham-Broomfield, 2021), I have unpacked two significant journal excerpts as an avenue to make sense of clinical practice scenarios that were emotionally triggering. Each reflection analyses the issues associated with Māori engagement in a health system that is embedded with Western ideologies. Here, there are subjective epiphanies that are informed by relevant literature to pave the way for change-innovation. The final section of the chapter weaves it all together by consolidating knowledge relating to the intersection of personal and professional identity.

## 3.2 Autoethnography

### 3.2.1 Background

Autoethnography emerges from a critical appraisal of conventional research methodologies, particularly within ethnography and sociology (Ellis et al., 2011). Its roots lie in the acknowledgment of the researcher's subjectivity as a valuable tool for understanding complex cultural phenomena. This methodology was forged by scholars seeking a more personal and reflexive approach to research, blending the objective observations of ethnography with the subjective insights of autobiography (Anderson, 2006).

Autoethnography places paramount importance on the researcher's introspection and storytelling capabilities. By integrating personal narratives with cultural interpretation, researchers explore the interplay between their own lived experiences and the broader socio-cultural contexts (Anderson, 2006). This encourages a deep dive into one's emotions, beliefs, and identities, offering a lens through which to understand the intricate nuances of culture. In today's diverse academic landscape, autoethnography continues to gain traction across disciplines as a transformative research process (Cooper & Lilyea, 2022). Its utilisation extends beyond traditional academic boundaries, resonating in fields seeking inclusive, authentic, and humanistic research approaches (Anderson, 2006). The methodology serves as a platform for marginalised voices, fostering a deeper understanding and appreciation of diverse cultural experiences (Ellis et al., 2011).

The emotional engagement inherent in autoethnography fosters empathy among readers, aiding in the comprehension of complex cultural dynamics (Anderson, 2006). Moreover, it encourages reflexivity, allowing researchers to critically examine their biases, enhancing transparency and authenticity in their narratives. With regards to this research project, the alignment between autoethnography and kaupapa Māori research methodology is rooted in their shared focus on Indigenous voices, self-determination, and cultural authenticity (Le Roux, 2016; Hiha, 2015). By integrating these methodologies, I have strived to uphold the principles of kaupapa Māori, centring Indigenous perspectives while fostering cultural reflexivity and respect. This synergy has contributed to the empowerment of Māori, enabling the reclamation of cultural narratives and knowledge within the research process, ultimately aiding in the decolonisation of research practices.

The deeply personal nature of this approach can also raise ethical concerns, especially regarding the portrayal of others involved in the narratives (Cooper & Lilyea, 2022). Researchers must navigate these ethical considerations sensitively to ensure the responsible representation of individuals and communities (Pelzang & Hutchinson, 2018). In my research, mitigation measures were made where ethical mandates have been adhered to. This is explained further in the ethics section below.

### 3.2.2 Positionality

When considering positionality and reflexivity within this research process, autoethnography provides the ability to use a personal-cultural lens to examine and analyse historical and current cultural realities that are affecting the Māori population within health. As autoethnography aims to investigate how social contexts influence our lives and realities, the researcher is heavily involved through single or collective modes of subjectivity (Ellis et al., 2011). This authorial methodology has enabled me to draw upon my own lived experiences and observations to make sense of what might be happening in the wider Māori nursing community.

### 3.2.3 Data Collection

Writing about personal feelings and perspectives through the art of storytelling and reflection enables autoethnographers to embark on a journey to make sense of our experiences. This method of enquiry can be therapeutic and promote a sense of agency and elevated levels of critical inquiry (Ellis et al., 2011). Le Roux (2016) adds that the narratives of personal experience assist in the understanding of unique themes and perspectives within the data. Unlike most research approaches, autoethnographical journal writing aims to evoke emotion for purposes of promoting personal, cultural or social change. Emotion has the power to shift the focus of the research towards the realm of interpretation by seeking meaning of the multifaceted themes within the literature, participant data, and researcher experience. When developing an autoethnography, it is important to keep in mind that the core foundation of inquiry is the researcher (Cooper & Lilyea, 2022). Therefore, I drew upon certain personal journal accounts that I had collected and decided to incorporate these into this research project.

From several journal entries, the two that I chose to include in this research were for various reasons. The first, was for reflection and processing emotions. As a Māori health professional, the excerpts evoked strong emotions in me. These situations challenged ethical and cultural beliefs, causing me to question the system's adequacy in handling sensitive matters, particularly concerning cultural practices and patient care. Engaging with these excerpts prompted the process to reflect on the emotions stirred by these events – feelings of sorrow, frustration, confusion, and a sense of being let down by the system.

Secondly, it was important to dive deeper into these excerpts to further understand cultural awareness, advocacy, and identity development. They highlighted instances where I encountered cultural insensitivity or gaps in providing culturally appropriate care. My engagement with these excerpts involved deeper introspection into my role as an advocate for culturally sensitive healthcare practices, and explored how I could contribute to bridging these gaps within the healthcare system, advocating for the respectful treatment and acknowledgment of cultural practices for Māori. Further, the aim was to understand how these situations aligned or conflicted with my personal and professional values. My journal served as a learning tool, allowing me to reflect on past experiences and seek ways to learn and grow from these encounters. Engaging deeply with the chosen excerpts facilitated brainstorming strategies or actions to better address similar situations in the future.

The final reason for choosing these particular excerpts was to understand the complexity with navigating organisational dynamics. The objective, in this respect, was to shed light on the challenges of navigating bureaucracy, policies, and protocols that might not adequately consider or respect cultural nuances and patient needs. These experiences could potentially lead to the questioning of existing processes and seek ways to improve and influence them positively.

These journal excerpts were written over a 24-month period. Journal writing enables the writer to express raw experiences, events and emotions. It is a form of reflection that involves engaging with unprocessed material to gain a deeper understanding of the event (Boud, 2001). To ensure clarity of my self-proclaimed epiphanies, I used Gibbs' reflective cycle to provide another layer of analysis to both journal entry excerpts to organise ideas, thoughts, feelings and themes.

### 3.2.4 Gibbs' Reflective Cycle – A Data Analysis Tool

Developed by Graham Gibbs in 1988, this cyclic framework provides organisation and structure to a learning experience. Paterson and Chapman (2013) state that Gibbs' reflective cycle is successful in facilitating an analysis of an experience, event or an aspect of service delivery. The model can be used for single or repeated situations with the aim of obtaining new perspectives whilst providing the learner with the tools to manage similar situations in the future (Ingham-Broomfield, 2021). There are six stages of the cycle. The first stage is description. Here, the learner can provide a detailed description about what happened, what the context was, the roles of those that were present, how the situation was handled, and what the outcome was (Paterson & Chapman, 2013). Within both reflections, the description sections contain the journal excerpts for purposes of portraying the lived experience and overall context. The second stage explores the learner's feelings recognising specific thoughts and emotions before, during and after the situation (Ingham-Broomfield, 2021). The third stage enables the learner to explore the positive and negative aspects of the situation. This is the evaluation stage. The fourth stage, analysis, is the most important aspect of the reflection as it provides the learner an avenue to make sense of the situation and make meaning from it. Here, the learner must examine the associated factors contributing to the positive and negative aspects of the event (Ingham-Broomfield, 2021). In the fifth stage, conclusion, the learner should summarise new learning and identify certain aspects of the event that could have been done differently (Paterson & Chapman, 2013). In the final stage, action plan, the learner can develop a plan outlining how they would manage future situations based on their reflective learning process (Ingham-Broomfield, 2021).

As an Indigenous insider, each journal entry represents my own perspectives, values and beliefs. The purpose of this process was to apply Gibbs' reflective framework to the two excerpts that represent the harsh reality that I have faced when striving to provide Māori-centric care, for Māori patients and whānau, in a world that is deeply rooted in Western ideologies. From an ontological standpoint, providing an additional layer of reflection highlights the reality of 'self' and who we are as practitioners (Paterson & Chapman, 2013). Epistemologically, these layers of reflection generate learning from and about the practice setting (Paterson & Chapman, 2013).

### 3.2.5 Rigour

Rigour refers to the trustworthiness of research processes that promote confidence in the overall data (Rossman & Rallis, 2017). Validity and accuracy are key components in determining rigour and whether the research is meaningful to a specific field. Despite debate about the use of traditional criteria to assess rigour, some researchers argue that these can guide researcher-development to meet appropriate requirements for academic integrity and accountability (Le Roux, 2016).

In autoethnographic research, multi-layered reflexive practices can promote dynamic modes of establishing rigour (Cooper & Lilyea, 2022). There is a continuum of autoethnographic research where emotional resonance sits at one end, and analytical reflexivity sits at the other (Le Roux, 2016). Situated across the continuum are paradigms that underpin the direction of each goal. Emotional resonance, or evocative autoethnography, evokes emotional resonance through deep narratives and stories (Ellis et al., 2011). At the other end of the continuum, analytic autoethnography draws on objective writing and verifiable data (Anderson, 2006; Le Roux, 2016). Within this research, the evocative aspect is derived from the journal excerpts. The analytic aspect is derived from the Gibbs' Reflective Cycle. Both can complement each other in research by providing a multidimensional and holistic understanding of a topic. Together, these approaches strike a balance between engaging storytelling and academic rigour, resulting in a research narrative that is both emotionally resonant and intellectually robust, offering a comprehensive perspective on the research subject. Further, Cooper and Lilyea (2022) recognise that, within autoethnography, social contexts and personal experiences cannot be separated. Relational contexts and personal narratives provide meaning to the research, and therefore, contribute to feasible and essential data.

The diverse orientation of autoethnography cannot be limited to a prescribed set of rigour criterium. Individualised criteria can be developed to determine the trustworthiness of autoethnographic research where they should be aligned with the paradigm, philosophical underpinnings, and the research aims (Le Roux, 2016). As a novice researcher, it is vital to draw upon recommendations that reflect this. Within this research project, subjectivity and self-reflexivity are important to assess researcher visibility, involvement, awareness and positionality. Resonance will be explored to understand the engagement and connection between the researcher and audience to ensure credibility, truthfulness and accuracy of the data. Here, gathering data from reflexive journal entries and semi-structured interviews will assist with positioning and further exploring the research findings (Cooper & Lilyea, 2022).

### 3.2.6 Ethical Considerations

In autoethnography, there are unique ethical factors to consider. When personal perspectives are narrated, it is important to consider the implications that the stories may have on others who are involved in the stories as parties or involved observers (Cooper & Lilyea, 2022). To protect their identity and privacy, pseudonyms and obscured identities are used to minimise any risk of harm. Additionally, self-care was carried out. Autoethnography can give rise to exciting discoveries of self but can also create vulnerability and emotional experiences (Cooper & Lilyea, 2022). To mitigate this, it has been vital to engage with research supervisors for support. However, the writing of this chapter elicited some unforeseen reactions where emotional regulation was necessary. It involves becoming aware of one's emotions, employing cognitive and behavioural techniques to influence those emotions (Holodynski, 2006). As this chapter is deeply rooted in subjective lived experience, several strategies were used to avoid emotional dysregulation. Reframing cognitive and behavioural responses is required by practicing mindfulness, debriefing with family, and recording experiences in a researcher journal. As the essence of this chapter is reflexive, mana (strength and identity) can be enhanced by promoting self-awareness, learning from experiences, clarifying values and goals, and sharing compelling stories. My aim is to boost personal power and influence, particularly within cultural and community contexts that value self-reflection and storytelling.

## 3.3 Exploring 'Self' within my Cultural Journey – A Preliminary Autoethnographical Story

### *Knowledge gained and knowledge lost.*

*As a child, I was always well-immersed in the culture with whānau being at the centre of my growing up. I remember being at the marae (meeting place) with my Nan, who always made sure to instil the tikanga of our people within my being. As I entered my teen years, hearing the stories of our ancestors always seemed a little far-fetched for my logical way of thinking. I didn't know why I was so sceptical. I spent less and less time at the marae. Less and less time with the whānau. I suppose it was because I was at high school and my values were changing. I went to a private school where everyone was white with rich parents. I remember feeling embarrassed that I didn't fit in. There weren't many other Māori children at this school but the few that were there were often treated pretty poorly. We were an easy target, and I was sick of being treated as 'other'. This was a significant turning point in time. I denied being Māori. I avoided going back to the marae. Avoided whānau events. I wanted to reinvent myself. Teachers and children always made awful comments about Māori. I always remained silent. As time passed by, I was starting to forget everything that my Nan had taught me. I dreaded the thought of having to go to a tangi (funeral) because I wouldn't know what to do! And sure enough, it happened. My cousin had passed away at a young age. This was one tangi I could not avoid. On our way to the marae, I had so much anxiety that I felt as if I was going to have a complete meltdown. I hadn't been to a marae in years. Hadn't seen my whānau in years. I knew that my Nan was already at the marae, so I called her to ask her to meet me out the front. She did. My heart was pounding, my hands were sweaty. She could tell that I clearly couldn't do this alone. And just like that, she gave me a quick run-down about what to do. She walked onto the marae with me. Showed me where to sit. Reminded me where to go and greet the whānau. Although I was relieved and grateful that Nan did this for me, I was embarrassed and ashamed that I literally needed my hand held. I pondered how I had lost all the knowledge that was instilled in me as a child. As a young adult, I was facing an internal battle with my identity and was worried that I may never regain the mana that I had lost.*

*During my nursing undergraduate years at university, we extensively covered Māori health. My lecturer was a proud Māori woman who I admired. She taught us about our history, injustices, and the current state of health of Māori. It was alarming and confronting. Somehow, it was resonating with my own experience. This Western world had diminished my being. Discouraged my identity. Disconnected ties to tikanga, whakapapa (genealogy), and the Māori worldview. She spoke about Māori mortality, morbidity rates, disparities, and inequities. While it was difficult to comprehend, the harsh reality of it all was evident in all corners of health. At that moment, I was inspired and committed to use my nursing training and career as an avenue for enhancing health outcomes for Māori.*

### *Lived experience and redirection.*

*Five years after graduating from nursing school, I had seen the state of Māori health first-hand. Working as a nurse in a large public hospital, it was clear that the structure of the health system was ineffective in applying Indigenous ideologies for Māori. There was an overwhelming sense of mamae (hurt) when trying to fathom the on-going discriminatory treatment that Māori were facing. Little did I know, I would be facing this from the same perspective.*

*As I left my doctor's office and was on my way to an urgent ultrasound and CT-scan, I wasn't prepared for what was coming next. Three days after the diagnostic tests, I still hadn't heard from my doctor with the results. As a nurse, I knew it did not usually take this long to get urgent results. I called my doctor's office several times and explained that I needed my results as soon as possible. The nurse on the phone was hostile and made me feel like a burden for calling. On day six following the ultrasound and CT-scan, I got the call. Cancer. My doctor explained that he would make urgent referrals to an oncologist and a surgeon. A week later, I met with both and was due to have surgery in a few days, followed by chemotherapy four weeks later. At the time of meeting with the oncologist, I was informed that the referral from my doctor was not timely. There had also been a rapid spread of the tumour following a second CT-scan. I was in a state of shock. Why was my referral so delayed? Why were my results delayed? Could further spreading of the tumour have been avoided if there weren't any delays?*

*I ended up have two surgeries and four months' worth of chemotherapy. It was a lonely and isolating sequence of events. My whānau lived at the other end of the country, and I did not want my friends to see me in the state that I was in. I was unsure about what support I needed. As I walked into the oncology suite to start another round of chemo, I sat in front of a mirror. Another reminder that my hair has all gone now. The steroids had plumped me up and I remember thinking that I was beginning to look much like a potato. I had to find humour even on the darkest of days. On that day, there was a new nurse looking after me. I'll call her Jane. As usual, I was shown to my single room to get my intravenous line inserted. Usually, the nurses struggle to find a good vein. I was extra dubious about Jane because she had not looked after me before. Like the other nurses, I was sure that Jane would be in a mad rush to get my treatment started so that she could attend to her morning tasks. I knew that resources were scarce, and nurses were overworked. So, I understood. But Jane was different. She sat next to me. Asked me where I was from. Asked about my family. She told me where she was from. She told me about her family. It was comforting. I still did not have my line in yet. We talked about the cancer and had a laugh about my potato-faced misfortune.*

*Suddenly, I wasn't feeling so nauseous anymore. Her ability to engage with me deterred my thoughts from the reality that I was going to be spewing my guts out in a few hours. This was the first time I did not feel like a statistic. Jane successfully inserted my line in and started my Bleomycin and Cisplatin infusions. Even though the medications were going in a vein, I could taste the toxic chemicals. Jane went for her break and came back to check on me. We chatted some more. She asked me why I did not have anyone with me during my chemo. I told her that I did not want my friends and family to see me like this. Plus, it would be a boring seven hours for them. It sure was for me. But then she asked me something really interesting. "Have you been offered any hospital Māori support services during the two months that you've been receiving treatment?" I hadn't. I could tell that Jane was not impressed one bit. Why hadn't any of my nurses or doctors offered me these services? And then I realised... Jane is Māori. She knew I was Māori and that's why she made the time and effort to get to know me. Whakawhanaungatanga (process of building connections). I felt a strong sense of rapport with Jane. She genuinely cared.*

*In all honesty, I probably did not need Māori support services. But it made me think... What about those who do need support? They probably were not offered these services either. I'm a nurse. So, I knew that these services existed.*

*It was time for my next infusion. Whilst Jane was setting this up, we talked about the services that were available to Māori patients. Even more so in oncology. She talked about the issues that Māori face in healthcare. She used to work at a marae-based clinic in the far north. She'd seen poor health outcomes for Māori first-hand. She stated that she was doing her postgraduate study in public health policy for Māori. She had a wealth of knowledge and so much passion! I knew that my own people were in peril. I wondered why I had not done something to help. I'm Māori. I'm educated. I'm motivated. I'm a nurse. Jane sparked something in me to use my position as a nurse to achieve positive health outcomes for Māori. I knew that I'd have to wait until I was well.*

*The experiences that I have been thrust into across my lifespan have redirected me onto a path of being self and knowing self. As I embarked on a journey into research and advocating for Māori health, it was imperative to immerse myself into the process of reconnecting with my whakapapa, tūpuna (ancestors) and tikanga. Thus, centring my wairua (spiritual strength and practice) and grounding my identity.*

## 3.4 Sorrow, Shock and Isolation

The first reflection is on an excerpt titled “sorrow, shock & isolation”. The situation occurred on a night shift in the operating theatre department of a large metropolitan public hospital in Aotearoa New Zealand.

### 3.4.1 Description

*It’s 3am. The corridors of the operating theatre department are empty and eerie. I usually love working night shifts. The uncertainty of what might come through the door. A laparotomy? A c-section? A tracheostomy? Not tonight...It’s an organ retrieval. I hate that my mindset automatically refers to these patients by the surgery that they’re having. They’re people!*
*I’m frantically scrambling to get the theatre ready for the transplant team to arrive. I find out that the patient has been in ICU, unresponsive, for quite some time.*

*It’s 5.55am. The liver is already on the way to the airport. I wonder who the recipient is. As the kidney vessels are being carefully dissected, I can’t help but feel a sense of loss.*

*It’s 7am now. The morning staff will start piling into the department soon. We’re nearly finished, thank God! As I finalise my nursing notes and re-organise the file, I notice that the Intensive Care Unit (ICU) admission form reads “ethnicity: Māori” – Why didn’t anyone inform us of this? My mind starts to race. No karakia was done. No Kaumātua (elder). No pathway planning to the morgue to avoid tea rooms, sluice rooms, nursing stations. I’ve let this guy down. We’ve all let this guy down. He’s allowing us to take his organs, to save the lives of others, and we can’t even get this right.*

*It's 7.55am. The floor co-ordinator is urging us to hurry up and get the theatre ready for the next case. We argue. I’ve called for the Māori Health Service to send the hospital Kaumātua to the theatre to say a karakia and facilitate the transfer of the patient to the morgue. “We’re not touching this theatre until he’s here” I insist. Despite my plea to ensure tikanga is upheld, she threatens to complete an incident report. My colleagues remain silent. They don’t understand either. Is this what my nursing career is going to be like? Will I forever be fighting a lonely battle against this system?*

### 3.4.2 Feelings

The three key emotions within this excerpt are outlined in the title of the journal entry. Sorrow. Shock. Isolation. From a general and human perspective, I felt a sense of loss for the patient and his whānau as soon as he came through the operating theatre doors. Although "frantically scrambling to get the theatre ready" was a necessary distraction, the realisation that we were about to remove all his viable organs before the rest of him was sent to the morgue was an emotive experience that had never been easy to comprehend – not that I showed it. Throughout the surgery, I was mindful of the space. The environment. I felt as though everything I did needed to be respectful, quiet and handled with care. The rest of the team did the same, which was pleasing to see.

Once I noticed that one of the patient's forms stated that he was Māori, my demeanour changed immediately. Initially, I felt guilty that I did not notice this earlier. But it was on an old ICU admission form that we did not usually need to check. As I rummaged through the rest of the notes, it was clear that his ethnicity was not mentioned anywhere else. The frustration caused me to blame the ICU staff for not handing this information over to us. I was thinking to myself 'we have an ethical and moral duty of care to address any sociocultural needs for patients and whānau'. I knew that within that particular hospital the documentation in every department required a daily assessment of sociocultural needs for all inpatients to be undertaken by a Registered Nurse. I wondered when this was last done, if ever, as I could not find any evidence of this. At this stage, I automatically assumed that the sociocultural aspect of the documentation was just a tick-box exercise for hospitals to demonstrate to their authority that they are, somewhat, being culturally safe in meeting the needs of Māori.

As I verbalised my concerns to the team – around karakia, Māori health service involvement, and planning a predetermined pathway to the morgue – no one seemed to care. This patient was giving his organs away to save the lives of complete strangers and we could not provide basic tikanga practices to uphold his wairua? The spiritual essence of his life force. It did not feel right.

As I battled with the floor co-ordinator, I remained firm in my stance to advocate for this patient. She made me feel as if I was an activist or a disrupter of the peace! As I was threatened with an incident report, I was beyond caring at this point. I could have quite happily done the same. But I did not want to stoop to the level of making threats. At this point, I was shocked and astounded that my colleagues remained silent. Did they not care either? Were they afraid of the floor co-ordinator? Or did they simply not understand? In the end, I felt a sense of relief that the Māori health service support arrived and facilitated the appropriate interventions for the patient. However, the relief did not last for long. I was emotionally drained from this whole debacle. It was clear that I was alone in this battle. Isolated and unsupported to advocate for the provision of Māori-centric care to Māori patients. I wondered if it was like this just in this department. Or this hospital. If this was a bigger issue than this isolated incident, then I was in for an exhausting career.

### 3.4.3 Evaluation

Trying to compartmentalise this event has proven to be difficult due to the personal, professional, cultural and political complexities at play. Despite this, advocacy had proven to positively impact on the outcome for the patient. Within healthcare, advocacy practices are malleable with the general sense of tailoring actions to uphold the rights of individuals and groups (Heck et al., 2022). Abbasinia et al. (2020) explain that advocacy encompasses the notion of defending and championing social justice. Upon evaluating the event, the reasoning for my actions comes from a place of striving for moral, ethical and cultural equity. From a critical theory perspective, this event has emphasised the need to transform political and social realities (Hardcastle et al., 2006). Situations like these give the opportunity to deconstruct the underlying issues relating to racism and discrimination, cultural health literacy, and policy structure.

Although there were positive aspects to this journal entry excerpt, there are several elements that are concerning. Firstly, there was poor communication about the patient's ethnicity or cultural needs. Without this valuable information, cultural support and intervention had not been arranged in a timely fashion. Secondly, when communicating the need for karakia and Māori health service support to my colleagues, they were disinterested and did not understand the cultural significance. Moreover, as I was trying to advocate for tikanga best practice, the threat of an incident report was verbalised.

### 3.4.4 Analysis

My ability to act as a strong advocate for Māori patients and whānau draws upon my experience and insight as a Māori. Without making assumptions about a single way to express being Māori, all Māori share one very real experience that cannot be denied. Colonisation. Although its effects may differ amongst different whānau, hapū (sub-tribe) and iwi (tribe), literature continues to urge the need for strong advocacy for Māori. Otherwise, we will never see equity in health access and health outcomes. As a Māori nurse, I recognise the positive impact of providing Māori-centric care to Māori patients and whānau. The evidence of its success is seen in their experience and overall outcome. Studies have shown that the development of cultural-clinical knowledge and skills, in conjunction with each other, have positively impacted on the experience for Māori (Huria et al., 2014). Wilson and Baker (2012) have explored the complexities for Māori nurses of practicing in two culturally different realms where successful advocacy starts with defending and promoting Māori customs in the clinical setting. Whilst I was able to facilitate karakia, engage with appropriate support services, arrange a pre-determined pathway to the morgue, and ensure wairuatanga was upheld, a new concern around cultural vulnerability for other Māori patients was something that could not be ignored. To successfully advocate for vulnerable patients, Abbasinia et al. (2020) explain that one must safeguard patients from cultural incompetence, ensure relevant patient information is communicated, value patient rights and beliefs, and develop strategies to be a champion for social justice.

Within this journal excerpt there is an obvious lack of communication about the patient's cultural needs. There was no handover or evidence of an up-to-date sociocultural assessment. Given that this Māori patient would be deceased after his organs are retrieved, I was concerned that appropriate Māori support had not been explored or offered to the patient and whānau. If it had, it certainly was not documented. Failure to recognise cultural needs automatically creates a barrier to receiving appropriate interventions or services, thus, further aiding in inaccessible healthcare and Māori health inequities. Pene et al. (2021) conducted a study on Indigenous patient and whānau experiences in the clinical setting where several participants expressed that there had been no cultural support offered. These responses were indicative of cultural disregard in supporting Māori in their hospital journey (Pene et al., 2021). Further, Wilson et al. (2018) explain that health practitioners are required to undertake a process of self-reflection of their personal and professional practice. This is the first step for achieving equity. Additionally, it is vital to ensure cultural responsiveness by exploring patient and whānau values, beliefs and practices with the aim of delivering culturally tailored care (Wilson et al., 2018). When analysing this event, there appear to be some intermediary factors apparent that are damaging to overall health and well-being. Such material circumstances, behaviours, and psychosocial aspects are indicative of a lack of cultural support, poor communication, and minimal respect for cultural practices. Theunissen (2011) suggests that these practices are a result of the structural design of the health system which have, historically, never valued the need to provide Māori-centric care. Although health organisations have developed policies that promote aspects of Māori-centric care, this journal excerpt exposes the reality that the application to practice is sub-optimal and Māori consultation and monitoring of these policies is required.

The second concerning theme that is apparent within the journal excerpt is a lack of tikanga application to practice. Tikanga refers to Māori customs, traditions and cultural practices and are informed by customary values within the Māori worldview (Duncan & Rewi, 2018). History shows us that socio-political factors within the Western world have continued to challenge our core values. Although Māori have often needed to adapt some aspects of tikanga, Duncan and Rewi (2018) explain that if tikanga practices are not accepted and nurtured, the effects on our well-being will be detrimental to our collective identity. A health professional's failure to engage Māori health support services, facilitate karakia, or follow tikanga practices around death and dying may be due to a lack of knowledge about mātauranga Māori and the Māori worldview. Thomas et al. (2022) suggest that this is caused by sociocultural differences. However, nurses must demonstrate cultural competency and safety to hold a practicing certificate. It is fair to recognise that all health professionals hold various levels of knowledge around tikanga processes. In this instance, staff did not call upon the Māori health support service for advice. This is culturally unsafe as it is the responsibility of health professionals to be aware of the appropriate support services available within their organisation (Pene et al., 2021). Māori health support services are in place to facilitate the application of tikanga practices whilst advising and educating clinical staff. Although I had arranged for this to occur, the support service should have been engaged prior to the patient entering the department.

Evidence suggests that there are several aspects within this event that are representative of racism and discriminatory practices. Came et al. (2021) explain that a lack of action in providing culturally appropriate intervention is a form of racism. This is explicitly linked to a lack of cultural awareness and tikanga practice. This is apparent in this situation whereby interpersonal and institutional racial discriminatory practices were entrenched within this health service. It would be unfair to assume that the health professionals in this situation were demonstrating acts of deliberate interpersonal racism towards the patient. Unfortunately, however, this was directed towards me. The behaviour and threats that I encountered from the floor co-ordinator were unjust and inexcusable. Despite trying to share knowledge about the need for Māori-centric process, particularly around death, there was an obvious disregard for the cultural needs of the patient and myself. Research suggests that this level of interpersonal racism, towards Māori nurses, is indicative of the continuous undermining of our need to advocate for Māori-centric care (Huria et al., 2014). This contributes to marginalisation, isolation, and internalised racism. Without any support from my colleagues during this event, it was clear that I was practicing in isolation.

With regards to institutional racism, this event depicts multiple system failings that should have been guided by robust frameworks to support patient and whānau cultural needs. The New Zealand health system has been dominated by Western ideologies where Indigenous worldviews and practices have been minimised (Theunissen, 2011). In a study by Graham and Masters-Awatere (2020), participants commented that mainstream health services have disregarded the spiritual aspect of Māori health and well-being. Furthermore, this breaches the Tiriti o Waitangi element of wairuatanga and is a direct effect of colonisation. Literature states that patients and whānau continue to experience limited autonomy in determining their cultural needs (Hunter & Cook, 2020). This barrier to cultural authority and control over well-being and customs suggests that tino rangatiratanga has not been upheld. The structural design of this Western health system poses questions around the cultural credibility and validity within their policy-making processes. Historically, policy and guideline development has failed to benefit Māori. These discriminatory policies are the overarching enforcers of institutional racism.

### 3.4.5 Conclusion

Reflecting on this event has been an emotive process. The journal excerpt depicts some implicit feelings of injustice, and the reflective process has been difficult as I've teased out the complexities within this experience. A significant discovery within this process is that our cultural awareness around Māori health inequities, practices and worldview is worse than I had thought. Not only are Māori patients receiving culturally unsafe care, but Māori nurses are being degraded and discredited for striving to advocate for the delivery of Māori-centric intervention. Additionally, the amalgamation of racism and unsupportive policies result in the delivery of culturally unsafe care for Māori. From a positive perspective, the health system reform has provided an opportunity for Māori input, decision-making, and monitoring via the establishment of Te Aka Whai Ora (Māori Health Authority). With the aim of indigenising the health system, by embedding Te Tiriti o Waitangi throughout its infrastructure, initiatives for deterring away from the negative effects of Western ideologies are underway.

From a personal-practice perspective, there are some aspects of this event that could have been handled differently. As mentioned, if Māori support service engagement was initiated earlier, in ICU, the entire scenario could have been avoided. However, there must be a degree of accountability within my own practice. In hindsight, it may have been beneficial to go directly to ICU to speak with the clinical staff and the whānau to establish what cultural needs were explored and if further support was required. On the other hand, it was 0300hours with only me and one other nurse to run the operating theatre for this case. So, resourcing constraints made it impossible to leave the department. As organ retrievals can be demanding and high-stress, time did not permit my ability to look more comprehensively into the clinical notes until four hours into the case – and the patient's ethnicity was not recorded in any of our theatre documentation.

While there are several complexities within this scenario to consider, resilience was a key contributor to the outcome of providing Māori-centric care in the end. As discussed within this reflection, my aim was to advocate and champion social and cultural justice for the patient. The confrontation with the floor co-ordinator was a result of differing values. Although it was an unpleasant experience, I view this as a positive learning experience for both of us. I am optimistic that she went away and researched tikanga processes and the Māori worldview whilst also reflecting on the event. Within my own practice, I was resilient enough to stand firm in what was right for the patient. To manage future situations, further development of resilience is required. Resilience is multifactorial and is shaped by values, life events, upbringing, and recurrent exposure to confronting and harsh situations (Tabakakis et al., 2022). This is where reflection is vital to make sense of the situation. In a New Zealand study by Tabakakis et al. (2022), participants described how the multifactorial elements of resilience equip nurses with the tools to be agents of change. Traynor (2017) supports this notion through the development of critical resilience theory. This theory encompasses the idea that political awareness of organisational processes and policies are required to ensure the sociocultural interests of patients does not fall secondary to the interests of organisations and systems (Traynor, 2017). To ensure continuous advocacy for Māori, it is imperative to develop critical resilience to promote the re-indigenisation of healthcare and social justice.

### 3.4.6 Action Plan

There is an obvious need for transformational change within the healthcare sector. To be an advocate for Māori-centric care and champion social justice, sharing knowledge is a key component of increasing cultural awareness amongst other health professionals. One avenue to achieve this is promoting the significance of holistic health and well-being for Māori. Most New Zealand nurses are familiar with Te Whare Tapa Whā, a Māori model of health and well-being (Durie, 2011). This would be a feasible starting point. Te Whare Tapa Whā recognises that the four dimensions of health – tinana (physical body), wairua (the spirit), hinengaro (the mind), whānau (the family) – are all connected and interrelated (Wilson et al., 2021). If one dimension is not fully functional, the others will be compromised. Unfortunately, wairua is often overlooked. This also relates to the concept of wairuatanga within Te Tiriti o Waitangi. Health professionals need to understand that the spiritual aspect of health runs deep within multiple plains of 'being'. It is related to whenua (land), mauri (life force), whakapapa, mana and tapu (sacred or prohibited). This research project aims to facilitate understanding and awareness of these concepts so that others may comprehend the cultural significance of such values.

To truly embrace new knowledge of holistic health and well-being for Māori, health professionals must transition from cultural awareness to cultural competence and safety. Cultural competency refers to the ability of healthcare providers to understand, respect, and effectively respond to the cultural and linguistic needs of their patients or clients (Ide & Beddoe, 2022). It involves the acquisition of knowledge, skills, and attitudes necessary for providing high-quality care to individuals from diverse cultural backgrounds. Cultural competency is about acknowledging and valuing the differences in cultural beliefs, practices, and worldviews and using this knowledge to deliver care that is sensitive to these differences (Ide & Beddoe, 2022). Although Ide and Beddoe (2022) emphasised the importance of cultural competency to bridge the gap between healthcare providers and the patients they serve, Irihapeti Ramsden believed that cultural competency is not just about knowing facts or customs; it is about actively engaging with patients in a way that respects their culture and provides care that aligns with their values and preferences (Ramsden, 1990).

However, Ramsden suggested that cultural safety goes beyond cultural competency and focuses on creating a safe and inclusive healthcare environment for individuals from all cultural backgrounds (Ramsden, 1990). Cultural safety recognises that some individuals may not feel comfortable or safe in healthcare settings due to their cultural background or experiences of discrimination. The central tenet of cultural safety is the idea that the healthcare system should be critically examined to identify and eliminate any practices or attitudes that perpetuate inequities and cultural insensitivity (Richardson et al., 2009). It's about making healthcare more accessible and welcoming for marginalised groups. Ramsden argued that cultural safety requires healthcare providers to reflect on their own biases and attitudes, as well as the institutional and systemic factors that may affect patient care (Ramsden, 1990). Cultural safety is a proactive approach to addressing health disparities and promoting health equity.

As a clinical nurse educator, I am well-positioned to provide education and training around the application of tikanga processes, for Māori patients and whānau, within the clinical setting. As indicated within this journal excerpt, health professionals require education about the importance of certain tikanga practices surrounding death and dying. It is imperative to educate colleagues about the relationship between tapu, karakia, and wairua in the context of death. As a person moves closer to death, they become increasingly more tapu. This affects everything and everyone that the person comes into contact with (Potiki, 2018). Therefore, clinical staff need to handle their body and tissue respectfully. When death does occur, which was evident within the organ retrieval event, the mauri dies but the wairua lives on (Selket et al., 2015). What's more, karakia is central to all aspects around death. Tuku wairua, a form of karakia, releases the spirit from the body. Karakia is carried out on multiple occasions throughout the tangihanga (cultural expression during death) to protect and guide the wairua. It is important for health professionals to understand that tikanga practices provide the wairua safe passage back to their ancestors. Understandably, most nurses will not be well-equipped with the components to carry out such tikanga practices. However, knowledge of this rationale may urge them to advocate for the patient by engaging in appropriate support services to facilitate this journey. Therefore, we all have a duty of care to know the role and function of our hospital Māori health service.

To ensure that clinical practice encompasses key concepts of Te Tiriti o Waitangi, this research enables deeper knowledge acquisition of kāwanatanga, tino rangatiratanga, ōritetanga and wairuatanga. To protect and promote kāwanatanga, engaging in this research project highlights the need for Māori input in decision-making around clinical care and local policies at all levels that affect Māori (Berghan et al., 2017). This includes whānau, Māori health services, Māori consultation and Māori leadership. Secondly, to uphold tino rangatiratanga, future research processes must promote the need for Māori autonomy and authority over health, well-being and customs as these are all taonga, or sacred (Hiha, 2015). Thirdly, ōritetanga will be strengthened by addressing and overcoming barriers to adequate health. This entails advocating against racism and discrimination, facilitating access to Māori health support services, and educating health professionals about relevant determinants of health, tikanga, mātauranga Māori and the Māori worldview (Huria et al., 2014). The objective here is to improve cultural awareness, cultural competence and safety, and cultural health literacy. Finally, wairuatanga is the fourth aspect that requires attention. As the spiritual dimension has been thoroughly discussed within this reflection, its relationship to Te Tiriti is from a practical sense within the way in which we recognise what is sacred, what deserves respect, and how we can apply protective measures (Came et al., 2020a). This entails utilising holistic models such as Te Whare Tapa Whā. Specifically, facilitate karakia, respect and protect taonga, advocate for rongoā (traditional healing practices) and mirimiri (massage), engage with whānau, and educate colleagues. Overall, the main goal is to normalise the idea that such processes as wairua cannot be separated from health, well-being or policy (Berghan et al., 2017).

The final action point born out of this reflection is enhancing critical resilience. When interpreting the literature, critical resilience is the ability to unpack and understand the qualities and experiences of 'the self' in relation to society (Traynor, 2017). It is about thorough investigation and discovery. In a practical sense, critical resilience encompasses the exploration of structures and frameworks from multiple perspectives (Traynor, 2017). From a policy perspective, it is essential to question and investigate the relationship between policy content and lived realities. With regards to health policies in Aotearoa New Zealand, historically there have been numerous policies that exploit Māori. This has been in the form of racism whilst failing to consider determinants of health, promoting only Western ideologies, omission of tikanga, and often suggesting that Māori are a burden on the health system. For example, the New Zealand Primary Healthcare Strategy does not include Māori equity or sovereignty considerations (Came et al., 2020a). Similarly, the New Zealand Cancer Control Strategy fails to recognise Māori as being sovereign Tiriti partners nor does it embrace wairuatanga in the context of Te Ao Māori – the Māori worldview (Came et al., 2020b). Further, it has often been unclear whether some policies were developed in consultation with Māori. It is vital to be well-informed with research and Māori health needs to closely unpack and question policies that effect Māori. Here, Indigenous experience and academic knowledge should be drawn upon for purposes of conducting future research and policy analyses. The event from this journal excerpt shows an obvious need to explore certain organisational processes. From a positive perspective, this has provided an opportunity for new learning and policy re-structuring.

## 3.5 Confusion

The second journal excerpt is titled "Confusion". At the time of writing the journal entry, I was new to the organisation and still navigating their processes. The patient was scheduled for surgery that day and the situation arose when I went to conduct his pre-operative assessment before coming to theatre.

### 3.5.1 Description

*He's in his 70's. He came from the far north. Travelling for 5 hours to get to the hospital. When I asked about his whānau, he said it's too expensive for them to come. There doesn't appear to be any affordable accommodation in close proximity and the hospital doesn't provide any accommodation. Nor do they help find any accommodation for whānau. During his pre-admission phone call, he asked if his wife could accompany him and stay overnight in a chair in his room. "That may incur a cost", they said.*

*I'm new to this hospital. Still trying to navigate how it all works here. I ask a manager about this patient's situation and why there would be a cost for his wife to stay overnight. I mean, he's in his 70s and from out of town. She rattles off different types of contracts and how these all work in the private setting. I'm confused. I'm now finding myself having to justify the need for Māori-centric processes to her. I realise it's a losing battle.*

*At the nurse's station, I ask the staff how I can get in touch with the hospital's Māori Support Service or Liaison. They looked puzzled. I could tell that I wasn't the only one experiencing* *confusion today. As I scrolled through the online hospital policies, I thought I'd struck gold! A contact number for a Māori Support Service at a neighbouring hospital. The policy suggested that we can utilise this service for Māori patients who require cultural support. So, I call.....*

*"Umm...I don't know what you're talking about" replied the confused woman at the other end of the phone. "We don't have any arrangement with your hospital. Yes, we are a Māori Support Service. But, only for our own organisation. I'm sorry, we can't help you". Again, confusion. Embarrassment. Dreading the next conversation I knew I needed to have with the manager...again!*

### 3.5.2 Feelings

Upon conducting the pre-operative assessment, it was clear to me that the patient was anxious about undergoing such a big procedure without the support of his whānau. When reflecting on this aspect of isolation, I knew that Māori often view hospitals as a place to die. The dichotomy between life and death must have been racing through his mind. Without the support of his whānau, he may have experienced a negative impact on the dimensions of hinengaro and wairua. I felt a sense of failure, on our part, in our abilities to promote whānau involvement in all aspects of care and decision-making. He is 70 years old and drove five hours, alone, to come to an unfamiliar environment in a different city for a complex surgical procedure. In my mind, there were some serious breaches in morality here. I pondered how our moral duty of care failed even before he stepped foot into the hospital. I understand that the private sector operates slightly different from the publicly funded sector, but we still fall under the overall health system. Although there are issues within the public health space, many of their public policies work towards addressing concerns associated with accessibility to appropriate services, such as transportation, accommodation and the need for whānau support. Much of our processes in private are guided by public policy, so I could not understand why we are creating a barrier to adequate whānau support.

At the time of writing the journal excerpt, I was new to the private organisation and was still trying to understand their processes. When the manager was explaining the different contract types, I felt as if I was talking to a lawyer or an accountant in a corporate environment. I did not feel as if I was conversing with a nurse in a hospital. It was all very foreign to me. I pretended to understand the explanation about the contracts. I didn't. To be honest, I didn't care. I tried to provide further insight into the patient's situation and the need for appropriate support. The manager kept bringing it back to the contract type. I kept bringing it back to the patient's needs. I was getting increasingly more frustrated and thought I'd better slap a smile on my face, thank her for such a thorough explanation, and leave her office.

Following this strange interaction, I realised that I needed to sort this out myself. From working in the public sector for many years, I was familiar with the role and function of their Māori health support services. Often, they would provide a Kaumātua to come and support Māori patients who do not have whānau with them. Lightbulb moment! Despite the nurses not being able to direct me to the local Māori health support service, I was excited to find a contact number for a regional Māori health service at another hospital nearby. As shown in the journal excerpt, the conversation did not go in the direction that I expected it to! I explained that our local policy states that we can contact this service to arrange support for our Māori patients. She was as confused as I was, and was adamant that there is no arrangement between our hospitals. What's even more confusing, is that the policy had been reviewed and updated only several months prior. Was there some conspiracy going on? Firstly, this hospital does not have their own cultural support service. Secondly, they claim to have an arrangement with an external service, which they don't. Thirdly, their guiding policy was a lie. It was blatantly obvious that there were some systemic concerns here.

### 3.5.3 Evaluation

The journal excerpt depicts several positive and negative aspects from the event. In a general sense, the idea of morality and moral courage is a positive highlight. As I pondered the underpinnings of this scenario, I wondered if other nurses had identified similar issues within this hospital but remained silent. Yalçın et al. (2021) explain that organisational culture and fear of disciplinary action inhibit nurses' ability to communicate their concerns about systemic processes that negatively affect patient care. As I was new to the organisation, I was unaware of such issues and found myself in a unique position to draw upon my moral sensitivity to be confident to advocate for the cultural needs of the patient. Kraaijeveld and Schilderman (2021) explain that morality is born out of personal values, experiences, upbringing, and views of sociocultural processes. The sensitivity aspect of morality is related to the ability to utilise one's emotions in moral decision-making and enaction (Kraaijveld & Schilderman, 2021). By drawing upon the emotions of empathy, injustice, confusion and frustration, I knew that I needed to seek clarity and further investigate the systemic issues at hand. By challenging the status quo, there was an element of moral courage evident as I did not fear any possible repercussions. I knew, within myself, that I was striving to do right by the patient.

Unfortunately, various negative aspects from this event were out of my control. However, I found it important to make the issues known whilst creating a dialogue about them. One significant concern was the organisation's lack of responsiveness to the patient's need for whānau to be present throughout his surgical journey. As mentioned in the journal excerpt, the hospital would allow the wife to accompany the patient and sleep in an armchair in his room. But this would incur an additional cost. It is understandable that this is a business where they have every right to enact additional costs wherever they see fit. However, there is little consideration for current Māori health status in relation to poor determinants of health because of colonisation. The historical effects of colonisation have placed Māori in a disadvantaged position. We know that there is a mismatch between the average Māori household income and the New Zealand living wage (Came et al., 2020a). Further, we know that a high percentage of Māori are unable to access health services due to financial hardship (Wilson et al., 2021), so it is concerning that we are not actively striving to overcome such barriers.

When engaging in health services, Māori experience unfriendly attitudes and culturally foreign environments (Wilson et al., 2021). However, Graham and Masters-Awatere (2020) explain that whānau involvement aids in the navigation of health processes whilst providing emotional support. As a healthcare organisation, it may be perceived that we did not meet our ethical, moral or cultural obligations in enabling the whānau to accompany the patient. When considering the whānau aspect, within Te Whare Tapa Whā, this dimension was compromised. As whānau could not be present, it was imperative to arrange an alternative support network through a Māori health support service. From previous experience, hospital Māori health services have been extremely helpful in providing support to Māori patients within their hospital journey. As mentioned in the journal excerpt, the organisation did not have an established Māori support service, nor did they have access to any external services. This was extremely alarming as it was clear that this could result in a negative patient experience with the risk of a poor outcome.

### 3.5.4 Analysis

As outlined in the evaluation section of this reflection, the main positive aspect of the event was the application of morality and moral courage to advocate for the patient and his cultural needs. These concepts are underpinned by moral sensitivity. Moral sensitivity is a crucial attribute that empowers nurses to feel confident when making ethical decisions. It serves as a moral compass, enabling nurses to recognise and empathise with the ethical dimensions of patient care. By being attuned to the values, beliefs, and needs of both patients and their whānau, nurses can navigate complex ethical dilemmas with greater clarity and compassion (Kraaijeveld & Schilderman, 2021). Historically, our clinical practice has been conditioned to rely on objectivity to inform our assessment and intervention processes. If we think about what constitutes moral behaviour, it is important to draw upon one's moral views and the interpretation of wider moral standards (Kraaijeveld & Schilderman, 2021). The ability to act is often driven by emotion, which may be viewed as dangerous. However, emotion regulates our behaviour and is dependent on our level of cognition. Kraaijeveld and Schilderman (2021) suggest that cognition, in the form of reasoning, provides an avenue to contextualise an event. Within this context, I could recognise the emotive reality that a lack of appropriate cultural support for this patient would impact on overall health and well-being. Therefore, the risk of a negative patient outcome was increased. I thought about my own experience as a patient during my cancer journey. A lack of whānau and cultural support probably had a profound emotional and spiritual impact on me during treatment and recovery. Luckily, I had Jane. Without essential support, I was probably at risk of experiencing isolation, heightened stress, anxiety, and an increased risk of depression. The absence of these crucial bonds may have led to a loss of cultural identity and disconnection, diminishing one's sense of purpose and meaning. However, those lacks seemed to enhance it for me. While the emotive aspect facilitated the re-exploration of past experiences in the context of this narrative, the cognitive aspect drove the output of my actions, investigations and interventions for this patient where I could draw upon my clinical and cultural knowledge and advocate accordingly. But, this led to recognising further moral issues where I needed to speak up.

Wiisak et al. (2022) state that healthcare professionals often fail to act when they observe breaches in morality due to fear of workplace repercussions or a lack of courage. However, silence can be an unseen threat to patient safety. Yalçın et al. (2021) explain that a failure to speak up can be a result of the workplace culture, organisational norms, or hierarchical structure. This is particularly evident within nursing. In a qualitative study done by Yalçın et al. (2021), nurses remained silent as they did not want to be viewed as troublemakers, labelled as problem-employees, expose their lack of knowledge about hospital processes, or they felt undervalued and became disengaged. These are some alarming issues, and I can admit that I have experienced some of these in the past. However, recurrent exposure to moral injustices and developing personal values have contributed to enhanced resilience in strengthening moral courage.

Moral courage is based on the ability to draw upon one's values, belief systems, and overall inner strength. Developing moral courage can be enhanced by overcoming fear of negative consequences when acting on moral justice (Wiisak et al., 2022). This is where the emotive aspect of moral sensitivity occurs. Of course, boundaries of this notion must be considered whereby the cognitive dimension of thinking comes into play (Kraaijeveled & Schilderman, 2021). Wiisak et al. (2022) suggest that ethical knowledge and ethical sensitivity are key components to moral courage. The output of these components is one's ability to identify questionable ethical and moral behaviours and speak up. For much of my career, I have been developing moral courage by speaking up for moral justice in the clinical setting. Now, this research is exceeding this framework and moving into the continuum of whistleblowing. Wiisak et al. (2022) conducted a study showing that nurses who display moral courage, via whistleblowing, are knowledgeable about ethical guidelines and have been exposed to previous morality breaches. This informs modes of decision-making and acts of courage. This study also recognises that such nurses display a sense of social responsibility for others and are well-respected by colleagues. Their personality traits reflect compassion, empathy and advocacy (Wiisak et al., 2022). At the time of the event, it did not feel as if I was acting in a morally courageous way. Upon reflection, I have been able to dive deeper into the underlying values of moral practice and critically analyse its relationship to its practical outputs.

Granted that there are some positive aspects of the event in question, it is important to recognise the negative aspects relating to inequity, accessibility barriers, and suboptimal organisational processes. As evidenced in the analysis of the first reflection, it is apparent that similar themes regarding racism, a lack of cultural competence, and questionable organisational processes are underlying factors within this journal excerpt. From a broader perspective, the overall patient journey and surgical continuum must be explored. Literature suggests that there are several barriers within health services that are difficult for patients to navigate in isolation (Freund, 2017). The structural design and complexity of health systems are not easy to comprehend. Additionally, patients and whānau experience unfriendly attitudes from health professionals, cultural barriers, an inability to understand medical terminology, financial barriers, a lack of trust in health services, and restrictions in accessing services due to geographical location and transport costs (Pene et al., 2021). Within the private sector, these considerations are often overlooked. One strategy to overcome these barriers is the implementation of a navigation framework. The navigator framework was introduced in the early 1990s as a response to the growing complexity of health services (Hilder et al., 2019). Its aim was to address inequities in high-risk population groups. As a barrier-focussed framework, it began within the cancer continuum and has evolved into various healthcare settings to date (Freund, 2017). Within Aotearoa New Zealand, it was adapted for use in cancer care for Māori and played a significant part in addressing barriers to equitable health outcomes (Hilder et al., 2019). Navigators are key facilitators and are often senior Registered Nurses or allied health practitioners. Historically, navigators provide service co-ordination, undertake health literacy assessments, educate patients and staff, provide health promotion, engage in policy guidance and development, and are knowledgeable in clinical practice (Hilder et al., 2019). In addition to these attributes, Māori navigators can potentially facilitate access to cultural support services, apply Māori health models, embed tikanga and the Māori worldview within their practice, mitigate accessibility issues to health services, and act as cultural brokers. When considering events from the journal excerpt, a Māori navigation framework would have greatly benefitted the patient. Further, this service would provide an avenue in guiding the reconstruction and development of the organisation's processes and guidelines where Māori patients and whānau are concerned.

When considering organisational standards and guidelines around addressing inequity issues for Māori, it is fair to recognise that the private sector often 'piggy-backs' off public guidelines. Within private, we are often working in isolation. So, a lack of collaboration in guideline development and implementation may be a contributing factor to the non-achievement of equitable health outcomes for Māori. However, the implementation of the Ngā Paerewa Health and Disability Services Standard may provide an opportunity to improve organisational processes and the delivery of culturally appropriate care for Māori (NZS 8134:2021 Ngā Paerewa Health and Disability Services Standard, 2021). The new standard was developed to promote and embed best practices that are person and whānau-centred. It provides a framework of expectations for all public and private health providers. It promotes autonomy and empowerment for service-users. Not only is it inclusive of Te Tiriti o Waitangi, but it provides clear outlines of service-provider responsibilities to become responsive to Te Tiriti (NZS 8134:2021 Ngā Paerewa Health and Disability Services Standard, 2021). When retrospectively assessing the standards against the events within the journal excerpt, it would not be in good faith to outline specific breaches as the service standards were not implemented at the time that this event occurred. However, it is important to outline the specific criteria indicators that are relevant to the situation as an opportunity to increase awareness.

The following criteria indicators, within the Ngā Paerewa Health and Disability Services Standard (2021), highlight relevant expectations relating to this event whilst ensuring accountability in culturally appropriate practices: "My service provider shall ensure my services are operating in ways that are culturally safe" (p. 25); "To facilitate equity approaches, my service provider shall be Māori centred" (p. 25); "My service provider shall promote an environment in which it is safe to ask the question how is institutional and systemic racism acting here?" (p. 30); "My service provider shall prioritise a strengths-based and holistic model ensuring wellbeing outcomes for Māori" (p. 30); "Service providers shall improve health equity through critical analysis of organisational practices" (p. 40); and "Prior to a Māori individual and whānau entry, service providers shall: (a) Develop meaningful partnerships with Māori communities and organisations to benefit Māori individuals and whānau; (b) Work with Māori health practitioners, traditional Māori healers, and organisations to benefit Māori individuals and whanau" (p. 47).

Clearly, the above standards are relevant to the journal excerpt event. They are directly linked to the patient's rights to culturally supportive processes, integration of Māori health models, and collaboration with wider Māori health practitioners.

### 3.5.5 Conclusion

Upon reflecting on this journal excerpt, there are many complexities that have been unpacked and analysed. When reading the excerpt on its own, it is difficult to leave emotion out of it or be objective in trying to make sense of the situation at hand. With a critical mindset, keeping the patient central to the reflective process has enhanced my ability to differentiate the moral injustices at play. What I did not include in the journal excerpt was the outcome for the patient. The rationale to omit this information was because the patient outcome was not positive. If I was to include this, I felt as though I would risk reflecting on the situation from an emotionally charged standpoint which would only portray grievance and blame. My intention was to reframe this event into a positive learning opportunity sparking curiosity and deeper meaning.

A key learning from this reflection is understanding the positioning of moral sensitivity and moral courage within my practice. I have recognised that one's own values and belief systems are beneficial in advocating for moral justice. It is about drawing upon cognition and emotion as equal forces in speaking up and investigating issues relating to organisational processes that inhibit the provision of equitable health services for Māori. An additional inhibitor in achieving morality is silence. While I felt as though silence was not an issue for me, literature does recognise that new employees often remain silent in reporting questionable moral practices. As I was new to the hospital, this does somewhat apply to me. As mentioned in the excerpt, I did have a conversation with a manager. However, nothing was done, and I could have escalated the situation further up the chain. Nonetheless, this experience has highlighted that this is something to be aware of in future. The new knowledge that I have acquired regarding 'silence' has provided some direction in supporting colleagues to deter away from these practices.

Another key learning from this reflection is understanding the value of a Māori navigation framework within private organisations. This framework has the protentional to transform Māori health experiences within the private sector by addressing determinants of health, facilitating Māori-centric care, increasing accessibility to relevant services, and providing advocacy as cultural mediators. Further, this framework may enhance intersectoral collaboration between public and private to ensure continuity of care whilst enhancing organisational processes and policies to meet the Ngā Paerewa Health and Disability Services Standard. The Standard may initiate the need for co-designing culturally appropriate services with Māori health providers and local iwi.

Overall, there are some important systemic issues to tackle. For personal development, I will need to further develop moral courage, refine analytical skills when exploring the ethical element of moral justice, and promote the application of the Ngā Paerewa Health and Disability Services Standard to practice.

### 3.5.6 Action Plan

With regards to further developing moral courage and ethical analytical skills, the first strategy is related to critical resilience as explored in reflection one. By engaging in policy development and review, I will be able to draw upon cultural knowledge, relevant research, and the lived realities of Māori patients and whānau. Having input into such guidelines will ensure that I am knowledgeable about their processes to identify and challenge cultural and moral breaches in practice. Also, Wiisak et al. (2022) explain that moral courage is developed through higher education and research. This is associated with enhanced critical thinking and engagement in research ethics. Additionally, it is vital to continue to self-reflect on situations like this event with the aim of making new discoveries of the ‘self’ while enhancing emotional intelligence.

As mentioned in the action plan of the first reflection, it is imperative to work towards improving the level of cultural awareness, cultural competency and cultural safety in colleagues. The Ngā Paerewa Health and Disability Services Standard emphasise the need for individuals and organisations, within both public and private services, to be accountable for the delivery of culturally appropriate services to Māori (NZS 8134:2021 Ngā Paerewa Health and Disability Services Standard 2021). These standards provide the opportunity to develop education initiatives about the practical application of such standards. These can be aligned with tikanga, Te Tiriti o Waitangi, the Māori worldview, and strategies for health professionals to be culturally responsive to Māori within the private sector.

## 3.6 Weaving it all Together

When I try to make sense of the autoethnographical entries and reflections within this chapter, there are some emotive threads that are confronting, but symbolic. Many of the lived experiences that I have faced appear to mirror that of the wider Māori population. My personal and professional life has been deeply immersed and affected by the health system. As a patient, and as a nurse. I lost my identity as a child but managed to regain it within a health system that could have crushed my wairua completely. It is somewhat contradictory, I know. Maybe it's resilience. Maybe it's naivety. I realise that my identity probably should not have survived. But it did. The health system is dominated at the governance level by white, straight, middle-aged men. The nursing workforce is dominated by white, middle-aged women. As a young, gay, Māori, cis-gendered male, the institution should have chewed me up and spat me out by now! Or maybe I am exactly where I am supposed to be. Perhaps resilience has been strengthened by the continuous undermining of my being which has reframed the notion of 'self' through a process of identity reconstruction. Upon reflection, I wondered what the societal underpinnings were for the overall loss of identity for the Māori population.

When I pondered social theory, I kept in mind the societal need to maintain optimum health within health systems. But in fact, the post-colonial Māori population has never experienced true optimum health and well-being. Could it be that our health system has been underpinned by the principles of functionalism? While functionalist societies work towards maintaining stability, their actions are guided by the level of societal detriment (Oliver, 1998). Functionalism in healthcare deems population groups who suffer from chronic conditions as social deviants and burdens. This has been the reality for the Māori population when engaging in health services. This is undeniably linked to colonisation and the suppression of language, customs, governance and autonomy.

Although functionalist behaviours may have impacted on my own identity, I have miraculously regained a sense of 'self'. Nonetheless, it has still been a lonely battle to advocate for Māori patients and whānau in the healthcare setting. My response to specific events, ideas and attitudes in each authoethnographical piece are influenced by my interpretation. Thus, recognising my place and role within this isolating war for social justice. Such interpretations and experiences have influenced my journey of rediscovering 'self' in a society that has threatened, disregarded, degraded, and discriminated against my ancestors for centuries. The process of associating meanings with experiences are indicative of symbolic interactionism. This sociological theory claims that meaning can be connected to objects, ideas, events, and perceptions between individuals and wider society (Armendariz-Dyer, 2020). Further, individuals will act and react based on their interpretation of such meanings which influence their place in society. Each autoethnographical account highlights the reoccurring aspects relating to differential treatment, inequitable access to health services, racism, and poor policy development within the health sector. As I reflect even deeper, my journey of 'self' cannot be in isolation. The negative experiences that I have faced are what many other Māori continue to face. In keeping with the analytic autoethnography methodology, data analysis encompasses a process of further reflecting on what collective meanings might be drawn from the individual account (Anderson, 2006). For Māori, past interactions and events have impacted on the level of engagement with health services. This has stigmatised our place in healthcare and society.

Although there are negative aspects threaded throughout this chapter, these will be reshaped and restructured in subsequent chapters to enhance the mana of this research. Through the lens of analytic autoethnography, change-innovation is possible for this project through the identification of where collective Māori autonomy, authority, and a strong sense of 'self' can be promoted and reaffirmed. To achieve this, our health system must enable us to reconnect with our whakapapa, tūpuna and tikanga. There must be an absolute commitment to eliminating racism by promoting cultural competence and safety, engaging Māori consultation in all Māori health affairs, ensuring Māori governance in policy development, and support the Māori nursing workforce to provide Māori-centric care for our people.

## 3.7 Conclusion

In conclusion, this autoethnography has provided a deep analysis of the subjective complexities associated with the personal and professional intersection that I have experienced across my cultural identity continuum. Despite early accounts of losing my cultural identity, being thrust into confronting situations has strengthened a sense of personal and professional resilience. Using the Gibbs' reflective cycle to make sense of my journal excerpts has been an emotive yet therapeutic experience. The reoccurring themes relating to cultural competence, racism, and organisational processes are evident throughout this chapter. Such concerns are directly linked to colonisation and Western ideologies which may have shaped a functionalist health system and society. Although these effects have been detrimental to Māori health and well-being, this chapter has met my personal aim of using such negative experiences to launch into an alternative perspective that reflects hope and the potential for positive change. Finally, this chapter demonstrates the value that autoethnography has on further developing knowledge of 'self' and a strong sense of identity. By diving deep into my experiences, I am further equipped with the tools, stamina and strength to advocate for the Māori population.

# 4 Chapter Four: Research Design

## 4.1 Introduction

This chapter examines kaupapa Māori as a research methodology for this project, inclusive of a qualitative approach and autoethnography. It begins with a foundational exploration of critical theory and unpacks the complexities and lived realities of colonialism in the context of the Māori population. Here, we can explore how kaupapa Māori research explores issues relating to Māori health outcomes whilst providing an avenue to decolonise Māori lived experiences. Further, this chapter demonstrates how kaupapa Māori methodology is woven throughout this research project. From an ontological and epistemological perspective, Te Ao Māori and mātauranga Māori are reflected within the project consultation process, autoethnography, researcher reflexivity activities, recruitment phase, interview process, data collection, data analysis and dissemination of the findings.

Four participants were recruited for the qualitative phase of this study. Ethical and cultural considerations followed the AUT Ethics guidelines, AUT Code of Conduct and Te Ara Tika guidelines. Ethics approval (22/361) was granted by the AUT Ethics Committee on the 16th of December, 2022 (Appendix B). Further, the data collection phase encompassed whakawhanaungatanga and tikanga to ensure authentic connections formed the basis of the researcher-participant relationship. Additionally, this chapter provides insight into the process of applying reflexive thematic analysis to the semi-structured interview data in the context of the kaupapa Māori approach taken within this research project. While the generation of themes was somewhat complex, the final three themes provided their own central organising concept, which aligned with an associated whakataukī (Māori proverb).

## 4.2 Research Question

How can the current experiences and perceptions of Māori nurses expose and reshape future realities for Māori patients and whānau when engaging in private surgical services?

## 4.3 Critical Theory

Research informed by critical theory strives to understand the challenges associated with sociocultural and historical knowledge and the oppressive impact that these have had on marginalised groups (Tyson, 2014). With a human rights agenda, there can be a pursuit for social justice by revealing issues surrounding power imbalances within society (Denzin, 2015). Critical theory creates a pathway that goes beyond recognising prevailing assumptions. Instead, deeper analysis of social phenomena paves the way for exposing and critiquing discriminatory practices whilst developing strategies to achieve positive change for oppressed groups (Tyson, 2014).

Conducting critical research strives to address issues around power and oppression which are associated with multidimensional factors (Denzin, 2015). Philosophically, the critical paradigm adopts a transactional epistemology. Here, the researcher has a strong connection and interaction with the participant (Kivunja & Kuyini, 2017). There is great significance placed on power and thought, as well as power and truth (Hardcastle et al., 2006). The researcher can incorporate their own bias, shared cultural experiences, and subjective interpretations of speech patterns and grammatical rules (Hardcastle et al., 2006). Critical researchers adopt the notion that social reality is created and developed by historical influences that are reproduced by people within society. Social constructs are often underpinned by social, political and cultural circumstances that are maintained by powerful parties that dictate how such constructs should function (Denzin, 2015). Thus, resulting in alienation and domination of the less powerful. By carrying out critique, critical researchers must thoroughly understand the social context in question. This can be in the form of lived experience, assumptions, and theoretical knowledge to frame ideological terms of reference that shape the research (Hardcastle et al., 2006). Given that subjectivity forms the basis of critical theory, the lens through which we see the world and conduct critical research determines the robustness of analysing specific social structures and systems (Denzin, 2015).

To understand the role of critical theory and its relationship to kaupapa Māori methodology within this research project, we must recognise the concept of colonialist discourse in the context of Indigenous societies. Colonialist discourse encompasses the viewpoint that Anglo-European culture is advanced, sophisticated and superior to all others (Tyson, 2014). In particular, superior to Indigenous and native populations who are viewed as savage, underdeveloped beings. In today's world, this is referred to as Eurocentrism. Here, European cultures deem Indigenous people as 'other' (Tyson, 2014). This occurs in the postcolonial world. Postcolonialism, a mode of critique that is directly linked to critical theory, analyses the impact that exploitation has had on colonised groups. It recognises that imperialism and superiority are the core drivers in exploiting Indigenous people, land and culture (Tyson, 2014). Postcolonial theory enables researchers to draw upon knowledge, ethics and political science to analyse and address issues relating to such historical complexities. This provides an avenue to redefine and re-establish the identities of colonised populations whilst seeking a power balance in the modern world.

Although postcolonial theory offers the chance for positive change, it may not be universal. Ritchie (2015) argues that, in Aotearoa New Zealand, Māori do not live in a postcolonial world. Māori continue to be marginalised by Western ideologies. Further, the Western infrastructure of the health system has historically promoted the suppression of Māori language, Māori identity, racial assumptions, and discrimination (Rolleston, 2020). Despite this being an ongoing theme, the rise of Māori academics and scholars have shed light on such suppressive behaviours for purposes of building an Indigenous onto-epistemology within research (Ritchie, 2015). Whether it be via direct or indirect activism, we have been able to introduce Indigenous knowledge into research, informing best practice that suits the needs of the Māori population. In doing so, we can begin to articulate our narrative and reclaim our place in the world. Literature suggests that there is great value in the Māori multidimensional aspect of 'being' (Hiha, 2015). As Māori are strongly tied to whānau, whakapapa, wairua and tangata whenua (connection to the land), there is a sense of centrality of single and collective identity (Wilson et al., 2022). Indigenous worldviews may have the potential to heal and repair historical discourse. While this seems to be an arduous journey ahead, the main academic priority is seeking agency and transformational change through the use of Indigenous methodologies in research.

## 4.4 Indigenous Health Research

Internationally, Indigenous health has been well researched. Issues relating to health inequities have shown clear commonalities associated with the effects of colonisation (Rolleston et al., 2020). Unfair, unjust and avoidable disparities in health are evident in Indigenous communities. Historically, Indigenous health research has failed to acknowledge the cause and effect of colonisation (Rolleston et al., 2020) where Indigenous populations have been the research subjects rather than the research participants and investigators. In recent years, there has been a substantial amount of research suggesting that Indigenous methodologies promote cultural awareness, competence and safety. This results in positive research outcomes that are beneficial for Indigenous health and well-being (Haitana et al., 2020).

In Aotearoa New Zealand, following the WAI 2575 report, academic institutions have encouraged Māori-centric research in the health sector (Rolleston et al., 2020). This paves the way for research and health-service development to deter away from dominant Western frameworks. This is evident in kaupapa Māori research where it aims to challenge Western ideologies through critical inquiry (Haitana et al., 2020). Linda Tuhiwai Smith developed kaupapa Māori Research as an Indigenous research approach rooted in the Te Ao Māori. This framework empowers Māori communities by ensuring their autonomy over the research process, addressing social justice issues, and upholding ethical standards (Smith, 2015). Smith's work challenges the biases of conventional Western research, emphasising a community-centred, interdisciplinary, and culturally sensitive approach. Her contributions have had a significant global impact on Indigenous research, promoting self-determination and cultural revitalisation within Māori communities and inspiring similar initiatives among Indigenous scholars worldwide (Hiha, 2015). In essence, kaupapa Māori health research enacts the analysis of health injustices and power imbalances which enables strategies for making the government accountable for their Te Tiriti o Waitangi obligations.

## 4.5 Kaupapa Māori Research

Kaupapa Māori research affirms Māori realities and is grounded in Te Ao Māori (Haitana et al., 2020) which encompasses cultural, epistemological and metaphysical foundations. Although it has no single approach, it centres on Māori realities, concerns and worldviews which aims to critique issues around colonisation, dislocation and deprivation (Haitana et al., 2020). Kaupapa Māori research explores and analyses Māori issues relating to sociocultural discourse through a Māori lens (Stevenson, 2018). This suggests that the aim is to decolonise Māori lived experiences by promoting a culturally informed research process. Although mainstream research has not favoured Māori autonomy, Hiha (2015) recognises a significant paradigm shift whereby kaupapa Māori research privileges Māori philosophies and values. This challenges the misrepresentation of Māori realities (Wilson et al., 2022), and exposes the need to indigenise the research space and gain sovereignty. By revitalising Māori knowledge, we can uphold the mana of our ancestors by legitimising Māori ways of being, knowing and doing. Therefore, the values that scaffold this kaupapa Māori research project are Te Ao Māori, mātauranga Māori and tikanga.

The Māori worldview is constituted of Māori philosophies and values. Therefore, it is vital to recognise the ontological standpoint in kaupapa Māori research. Ontology refers to the study of reality, or simply the investigation of ‘being’ (Kivunja & Kuyini, 2017). Further, underlying belief systems must be explored to understand the nature of our existence. For Māori, existence is informed by establishing and maintaining connections and relationships. First and foremost, connections and relationships are established through whakapapa. Whakapapa is the interconnectedness of whānau, hapū and iwi, and informs being, knowing and living in Te Ao Māori (Stevenson, 2018). It is important to understand that whakapapa connects us to all things within the realm of being and contributes to the way in which we make meaningful connections with others.

This is the essence of whakawhanaungatanga. As a significant construct within Māori culture, whakawhanaungatanga enables the establishment of connections and building meaningful relationships (Haitana et al., 2020) which was evident in this research project.

For Māori, ontology and epistemology are co-dependant and interrelated (Stevenson, 2018). In a general sense, epistemology refers to the study of knowledge. It involves investigating knowledge acquisition and the comprehension of 'truth' (Kivunja & Kuyini, 2017). Kaupapa Māori epistemology is underpinned by values and principles that scaffold Māori culture (Stevenson, 2018). Such values and principles are deeply rooted in the connection between whakapapa, whakawhanaungatanga and Te Ao Māori. Kaupapa Māori epistemology is reflected in the knowledge of the Māori worldview and how we acquired this knowledge (Wilson et al., 2022). This is mātauranga Māori and is deemed as taonga. When comprehending the significance of whakapapa, there is a genealogical aspect of sharing knowledge across generations (Wilson et al., 2022).

Thus, this project has a kaupapa Māori theoretical underpinning, supported by critical theory, within the Indigenous research paradigm. In the sections that follow, I describe how this approach has informed each of the research phases and processes.

### 4.6 Consultation

In addition to consultation from Māori research supervisors when planning this project, it was essential to seek advice about the research proposal and plan prior to its full development. I did this with two well-respected Māori consultants in the health space. One is a leader in public health and research where much of his career has been focused on Māori health advancement and anti-racism. The other has worked towards growing Māori clinical leaders in Aotearoa New Zealand as well as sitting on several high-level health boards as a Māori representative. Whakawhanaungatanga enabled the establishment of our on-going relationships. Although I had no immediate link to their whakapapa, what connected us was the commonality of our worldview and the knowledge that we shared around the need to improve health outcomes for our people. The advice that followed was instrumental in the design of my research. Both had highlighted that, in order to be an agent of change for Māori, I needed to start exploring the concept of 'self'. We discussed the key drivers within the private health sector being associated with logic, science and rationality where this linear way of thinking and being has often been driven by profit. From a Te Ao Māori perspective, we discussed the need for circular thinking within the kaupapa Māori research space. To do this, it was pertinent to reconnect with the deepest level of 'self' through authenticity, honesty and integrity. These mana-enhancing attributes were truly revitalised when writing the autoethnography chapter for this thesis. It is important to note that there must be an intersection between linear and circular thinking within this project to grasp and unpack the complex nature of achieving the research aim.

## 4.7 Autoethnography

Autoethnography as a methodology and method is explored fully in the autoethnography chapter. In this chapter I focus on how it connects personal and cultural processes, and how the concepts of autoethnography and kaupapa Māori methodologies intersect.

When writing the autoethnography chapter, it was imperative to maintain authenticity through a Māori lens and worldview. Autoethnography provided the opportunity to maintain my right to define what it means to be Māori in the research space. This was indicative of upholding tino rangatiratanga. As a key component within Te Tiriti o Waitangi, it embodies absolute authority and autonomy over all things taonga (Came et al., 2020). The subjective lived experiences within the autoethnography chapter are deeply intimate and sacred to my cultural and professional journey. Therefore, retaining sovereignty of such personal stories without the dictatorship of Western frameworks was vital.

Similarly, taonga tuku iho (cultural continuance) was an element of kaupapa Māori that was threaded throughout my autoethnographies. Taonga tuku iho refers to the notion of cultural continuance and development (Hiha, 2015). Before setting the scene about my cultural journey and selecting meaningful journal excerpts to reflect upon, a reflexive baseline needed to be determined. Reflexivity is the self-awareness of the researcher-environment relationship (Dodgson, 2019), and involved examining my own beliefs, values and practices to understand how they might influence the research. For thorough identity analysis, I explored my own cultural identity formation to understand how social organisation and co-ordination has functioned in my life (Jacobson & Mustafa, 2019). It enabled the exploration of the relationship between my identity and environmental interactions so, knowing that identity cannot be removed from research processes, I recognised that race, citizenship, culture and political influences were indicative of my research positionality as an Indigenous insider. I applied my own uniquely Māori values, beliefs, perspectives and practices to the autoethnography process (Pelzang & Hutchinson, 2018). Following this, I was able to set the scene by sharing personal accounts of the influences that challenged my cultural identity throughout my formative years. These came from my journal and were selected based on the relevant details within each narrative. This storytelling activity aided in the understanding of the complexities associated with the personal and professional intersection that were unavoidable across the cultural identity continuum. Although this autoethnography was somewhat confronting and emotive, it authentically enhanced a sense of cultural integrity, as a Māori researcher, guided by the principle of taonga tuku iho.

## 4.8 Recruitment and Participants

This research project has used purposive sampling to select participants. Purposive sampling enables the generation of themes and ideas that can be compared and contrasted with key themes identified in the literature (Denieffe, 2020). Campbell et al. (2020) state that purposive sampling may require only a small number of participants. This gives the researcher the opportunity to focus on deep critical analysis of their subjective accounts. To meet the inclusion criteria, participants needed to be of Māori descent and currently practicing as a Registered Nurse in a private hospital within Aotearoa New Zealand. They were required to have a minimum of two years' experience in the private surgical setting and had nursed patients and whānau, who identify as Māori, within the specified timeframe. The exclusion criteria outlined that colleagues of the researcher within the same hospital be excluded to avoid any conflict-of-interest issues. Participants were from various parts of the country and interviews occurred via a videotelephony system. While online video platforms can never fully replicate the experience of in-person meetings, they do provide a valuable tool for connecting with others, especially when geographic or other constraints make physical meetings impossible. Such platforms enable kanohi ki te kanohi (face to face) by encouraging us to maximise the benefits of purposeful whakawhanaungatanga from a distance.

Recruitment was by an advertisement which provided an explanation of the study, including the inclusion criteria (Appendix C). Interested participants were given an information sheet (Appendix D) that reiterated the inclusion criteria, provided specific information about the research aim, significance of the research, ethical considerations, confidentiality, consent, study process, and what would be done with the study results. To ensure the advertisement and information sheet could reach all areas of Aotearoa New Zealand, specific networks were utilised to recruit participants who had graduated from Ngā Manukura o Āpōpō (National Māori Clinical Leadership Course). The Director of this organisation had disseminated the advertisement, via email, to all graduates that had completed the course. Secondly, the advertisement was also disseminated to all members of the New Zealand Private Surgical Hospital's Association via the organisation's Executive Director. Possible participants were able to email the primary researcher, via the email provided on the advertisement, to express their interest in taking part in this research project. Potential participants were then emailed the full information sheet.

In total, four participants expressed interest. Once it was determined that each participant met the inclusion criteria, they were provided the opportunity to dictate their own time frame to consider whether or not they would like to be interviewed. It was important to enable participant autonomy during this phase to avoid any power imbalance within the researcher-participant relationship. During the recruitment phase, the participants were given sufficient time to review the participant information sheet and consider their invitation to be interviewed. This promoted tino rangatiratanga by following the guideline of mā te wā, all in good time (Hiha, 2015). Similarly, noho puku (respecting autonomy and reflection) was an important consideration to allow the participants to define when and how they would like to be interviewed.

Prior to interviewing participants, I had met with each participant, individually, to start the process of forming connections through whakawhanaungatanga. This provided a sense of comfort and ease before setting an agreed date and time to carry out the official interview. During each interview, via Microsoft Teams, the information sheet was revisited before obtaining consent via the oral consent protocol (Appendix E). The videoconference consent protocols had their own recording, separate to the actual interview, and each was separately transcribed. Each interview consisted of nine semi-structured interview questions (Appendix F).

## 4.9 Interview Process

When designing the semi-structured interview questions, my aim was to ensure that these were values-based and mana-enhancing, and underpinned by Te Ao Māori, mātauranga Māori and Te Tiriti o Waitangi. It was vital that the core questions and probing questions were consistent with my values where I left myself space to appropriately respond to the participants' needs during the interviews.

Semi-structured interviews enable a thorough understanding of a participant's thoughts, feelings, values, perceptions and experiences of a particular topic (DeJonckheere & Vaughn, 2019). With the use of open-ended and theory-based questions, data generation can be reflective of discipline-specific constructs and participant experience (Galletta, 2013). Questions within this project were clearly connected to the research aim where core themes from the literature review framed each question. Within this research study, the interview questions were open-ended and clear with the use of familiar language. They were predominantly in English, but common te reo Māori (Māori language) was used to ensure the authenticity of kaupapa Māori.

Generic questions began the process for the participant to start articulating generic features of their experiences (DeJonckheere & Vaughn, 2019). Next, probing occurred to explore significant elements of the narrative for the researcher to gain clarity on particular details that were relevant to the topic. Planned core questions, and possible follow-up questions, were designed to elicit responses that addressed the research aim and question (DeJonckheere & Vaughn, 2019). Additionally, it was important to explore the data with greater specificity to understand contextual nuances of the participants' narratives (Galletta, 2013). Throughout the interview, researcher-engagement was maintained to identify metaphors or ideas that reflect the researched phenomena (Galletta, 2013).

Each interview commenced with an opening karakia to create a safe space. This was imperative to our tikanga and also enabled the acknowledgement of our ancestors whilst centring our collective wairua. When addressing each interview question, aroha ki te tangata (expression of love to other people) was crucial in respecting the experience that each participant shared. Hiha (2015) explains that kaupapa Māori methodology incorporates the principles of titiro (look) and whakarongo (listen) when interviewing participants. This is particularly important when attending to participant behaviour and tone, and responding sensitively (Kennedy et al., 2015). Therefore, ensuring a sense of manaakitanga (nurturing relationships/hospitality/respect). Kaitiakitanga (process of achieving guardianship) was also evident throughout these processes. Kaitiakitanga refers to the ability to listen respectfully and empathetically, and protect the sacred space (Stevenson, 2018). Here, it was important to acknowledge their experience and appreciate their ability to share their stories. Finally, each participant was given the opportunity to provide further clarification or ask any questions before I carried out a closing karakia.

### 4.10 Data Analysis

During the reflexive thematic analysis phase of this project, the underpinnings of kaupapa Māori naturally came to light. Across the coding and theme generation phases, most core components were related to political discourse, Te Tiriti o Waitangi, mātauranga Māori and Te Ao Māori. When practicing reflexivity during the analysis, there was a mutuality of worldviews that were shared between myself and the participants. It was clear that our shared worldviews tended to spill over into clinical practice. However, these were the key features of establishing a sense of cultural agency and identity throughout the personal-professional intersection that was collectively evident.

As thematic analysis utilises key techniques to identify patterns in meaning to develop themes (Terry et al., 2017), it was used for this research project to analyse data from the semi-structured interviews. Reflexive thematic analysis focuses on the researcher's subjective view as an integral part of the analysis process (Braun & Clarke, 2021). Reflexive thematic analysis for this project was experiential in orientation to explore the participants' thoughts, feelings and actions in relation to theoretical assumptions (Terry et al., 2017). The practical application to this study followed six phases. These were data familiarisation, initial code generation, generating initial themes, reviewing themes, defining and naming themes, and producing a report (Campbell et al., 2021). As I moved through each phase, reflexivity occurred to promote deep engagement with the data by aiming to comprehend the impact that I had on the data collection and analysis (Terry et al., 2017).

The foundation of thematic analysis starts with familiarisation (Braun et al., 2019). It involves comprehensive steps to understand raw data, including re-reading transcripts, re-listening to interviews, and re-watching recordings (Braun & Clarke, 2021; Terry et al., 2017). This iterative process aimed to discern patterns, assumptions, and worldviews, fostering curiosity and prompting questions about participant experiences. Observational notes, documented as margin comments in Microsoft Word, evolved into synthesised insights consolidated separately and aligned with the research aim through further synthesis.

Transcription, the conversion of spoken words to written data, demands attention and interpretive effort (McGrath et al., 2019; Braun & Clarke, 2013). Employing Microsoft Teams' transcription function generated the initial data 'bones,' subsequently verified by reviewing video segments for accuracy, especially concerning non-transcribed elements like te reo Māori words. Videorecordings allowed analysis of facial expressions, body language, and gestures (Kvale, 2007), enriching the orthographic transcription process for thematic analysis (Braun & Clarke, 2013).

For readability, speaker identities were indicated, employing a hanging-indent system for turn-taking. Humour, pauses, and cut-off speech were notated to capture nuances that enhanced interview authenticity (Braun & Clarke, 2013), validating the transcription process (Kvale, 2007). Post-application of notations, punctuation, and grammar, a final review against videorecordings was conducted.

Despite the time-consuming nature, independent transcription by a novice researcher enables a deep immersion into the data, ensuring reliability through recurrent edits and reviews (McGrath et al., 2013). For this reason, I carried out this process. Following transcription completion, returning transcripts to participants for verification of accuracy and authenticity is advocated (Moyle, 2014). Therefore, these were disseminated to the participants within this project. This practice empowers participants to rectify any inaccuracies, promoting agency and critical reflection (Hiha, 2015), and aligns with tino rangatiratanga and manaakitanga values, fostering trust and respectful relationships.

During observational notetaking, I found myself becoming more curious about the data and began to ponder further questions relating to participant behaviours, emotions, and the depth of their stories. When reviewing the notes from the entire dataset, further synthesis occurred to align the key points with the research aim. At this point, it seemed imperative to write a reflexive piece about what I saw in the dataset. As I wrote the reflexive piece shown below, it was evident that my core values were coming to light:

*I think that I am finally comprehending the ups and downs of the arduous road to maintaining agency of my identity. When I think back to my own cultural journey across my lifespan, there were some challenging experiences that appear detrimental at face-value. The 'white washing' throughout my adolescent years. Becoming 'another statistic' as a Māori patient. The isolation when striving to advocate for Māori patients. Although these seem incredibly disheartening, these life events have brought my values and worldview to the forefront of who I am. I am Māori. Everything else comes later. When I was carrying out the familiarisation phase of this data analysis, it was evident that the participants were much the same. As I re-watched the video recordings and re-read the transcripts over and over again, their passion and motivation shone throughout. At times, each participant portrayed discouragement and deflation when talking about their experiences. But this did not last for long. Their values and worldviews remained focal to their narrative. This re-centred their stories in a positive light. I could not help but feel an alignment of our collective journeys. There was a parallel which highlighted the commonality of values and worldviews bleeding into our clinical practice. I felt as though this level of mutuality further connected me to each participant. A deeper level of whakawhanaungatanga.*

While familiarisation provides an avenue to identify ideas within interview data, generating codes requires deep engagement to systematically organise ideas succinctly and rigorously (Braun et al., 2019). Coding can be inductive or deductive. Inductive coding requires the researcher to generate codes directly from the data (Braun et al., 2019). The researcher sets aside any existing theoretical concepts and focuses only on the data (Terry et al., 2017). Essentially, it is a data-led approach. On the other hand, a deductive approach requires the researcher to bring existing theoretical concepts and underpinnings which provide the basis of how the data is viewed and interpreted (Terry et al., 2017). For this very reason, a deductive approach was naturally employed for this reflexive thematic analysis as I entered this phase with a kaupapa Māori lens and a Māori worldview. By employing a thorough and systematic approach, important segments of data should be identified (Terry et al., 2017). The research question guides the coding process. When carrying out this process, data of interest was highlighted throughout each transcript. Here, segments were determined. Most segments were provided with a few words or a phrase that related to the research question. This is where codes were generated. Data segments often contained multiple codes, and others were not coded at all due to not being relevant to the research question. Some codes were semantic. This means that the surface meaning derived from their segments were obvious and explicit (Braun et al., 2019). However, many codes were latent. Latent codes contain underlying messages and theoretical assumptions (Terry et al., 2017). Given my deductive approach, latent codes were often related to Te Ao Māori, mātauranga Māori, Te Tiriti o Waitangi or political discourse. The codes were meaningful, and patterns were identified. Each code was recorded on an electronic sticky note using a Miro Board. They were colour coded to represent each participant. This was an important factor because I did not want to lose sight of the stories that came from each participant as they are central to kaupapa Māori research. Codes were continuously reviewed and refined throughout the rest of the analysis process. From a reflexivity standpoint, it was important to keep in mind kaupapa Māori underpinnings when generating codes. As mentioned in the reflexive piece below, kaupapa Māori methodology concepts were included in the code generation process:

*As I began to code the data, I thought about the shared experiences between the participants and myself. These scaffolded the coding process where I embraced my gut instinct of identifying the underlying messages. As I mapped out the underlying meanings and assumptions, I remembered a conversation that I had had with a Māori leader that provided the rationale as to why my thinking was often circular, and why the participants' stories held deeper meaning. Our stories are never direct, and they are often drawn-out and complex. They are figurative in nature. And somewhat oratory. I thought back to our ancestors and how their stories were told by drawing upon Māori mythology, art, waiata (song), karakia, and poetic nuances. Facial expression, gestures and emotion framed the art of storytelling. When I was generating codes, this was in the back of my mind where I could identify metaphorical similarities and parallels with that of my own assumptions and experiences. And it all came back to the effects of colonisation. But I needed to reframe my thinking to ensure my coding approach focussed on the positive aspect of indigenising healthcare in the private surgical setting. As I generated codes, I recognised that some overarching kaupapa Māori principles were attached to many codes. Thus, they needed their own code.*

Following the code generation phase, theme development began. It is important to note that themes do not emerge in reflexive thematic analysis (Braun & Clarke, 2021). Rather, they are generated by the researcher through pattern formation and identification (Terry et al., 2017). Within this study, the research question guided pattern formation of the codes. This meant that further code examination was required. I collapsed, combined and clustered codes to easily identify meaningful patterns. Using the Miro Board, similar codes were clustered together which highlighted possible candidate themes. Six candidate themes were evident at this stage. They were: (1) workforce development; (2) organisational accountability; (3) a lack of collaboration; (4) the need to provide Māori health support; (5) cultural incompetence; and (6) poor policy development.

Although the initial candidate themes were somewhat specific, it was difficult to develop a central organising concept that related to the research question. This is a core idea that underpins a theme (Terry et al., 2017). Additionally, many of the candidate themes represented an element of negativity which was not the direction intended for this analysis. This research aimed to be mana-enhancing with the purpose of developing strategies for positive change-innovation. Due to these factors, the codes were revisited where some themes were amended, and new ones were generated. This was the reviewing phase and is a necessary element of reflexive thematic analysis (Braun & Clarke, 2019). The new themes needed to be somewhat separate and distinct to one another (Terry et al., 2017).

The defining and naming phase requires the researcher to shift into the mindset of interpretive orientation. Here, it was imperative to explore patterns within the dataset that told a story (Terry et al., 2017). Each theme contained an overarching whakataukī that was mana-enhancing and in keeping with a kaupapa Māori approach. He kai kei aku ringa (there is food at the end of my hands) encased the first theme. In the context of this research, this represents the attributes that Māori nurses bring to the health space. The participants' perceptions, experiences and stories exuded resilience and passion. Māori nurses bring a Māori worldview to their practice, which is unique and dynamic to patient care. This whakataukī highlights the need to empower the Māori nursing workforce to create positive change for Māori patients and whānau. The central organising concept for this theme as based on the value of Māori nurses.

The second theme is reflected through he waka eke noa. This signifies a collective journey. With the common goal of enhancing Māori interests and improving Māori health outcomes, we must collaborate with others to successfully achieve this. The central organising concept for this theme is based on collaboration and co-design. Based on the dataset, this theme provides an avenue to examine Māori governance, policy development, research opportunities and building relationships with Māori communities.

The third theme refers to whaiwhia te kete mātauranga. It is about the development and delivery of educational initiatives to, individually and collectively, enhance knowledge. The central organising concept for this theme is based on a journey towards cultural awareness, competency and safety. This theme enables the exploration of patient experiences articulated by the participants, employing multiple learning modalities, and the pursuit of equity, self-determination and autonomy for Māori.

The process of developing, reviewing, defining and naming themes required focus and direction. As mentioned in the reflexive piece below, there were some critical decisions that needed to be made in order to ensure the themes were mana-enhancing:

*Up until this point, much of my research has highlighted the detrimental effects that colonisation has had on Māori identity and health outcomes. As I was clustering codes, I found that it was easy to fall into a negative spiral. I thought about my own perceptions relating to racism, discrimination, poor public policy, land confiscations, identity minimisation, and the suppression of culture. It was clear that I was starting to blame the Western world for these perceptions. Although colonisation is responsible for this historical discourse, there was optimism in the participant stories. When I generated the first candidate themes, I needed to revisit the videorecordings as I was not yet satisfied with these themes. I needed to empower the participants. Give credence to their narratives. So, I reframed my mindset to deter away from focusing on 'inaction'. Rather, see this as an opportunity to influence positive change. This change in thinking enabled the formation of new themes with clear central organising concepts. As I pondered on the final themes, I wanted to ensure I kept the essence of 'positive opportunity' and maintain the mana and taonga that the themes held. Thus, each theme needed their own whakataukī. It was a humbling experience to draw upon whakataukī that have been important within my own whānau. They are influential, and reflective of my own worldview.*

The themes, along with quotes and further discussion, are presented fully in the findings chapter.

### 4.11 Ethical Considerations

Privacy and confidentiality processes adhered to the AUT ethics guidelines and AUT Code of Conduct for research. Data minimisation and use-limitation was maintained by limiting the amount of personal information that was collected and retained. The participant information that was collected was only relevant and necessary for the needs of the project. Participants were asked not to identify the name of their employer.

Transparency was maintained by being open and honest about what information was collected and how it would be used. Within the informed consent process, a clear explanation was given to the participants about the type of data that would be collected, the purpose, how the information would be used, data security and storage, and participant rights. This was communicated in an information sheet and a verbal explanation.

The security of participant details was maintained by giving all electronic and paper information to the primary research supervisor who kept these stored on the AUT password-secured electronic/computer database. This data was accessible only by the researcher and primary supervisor.

It was anticipated that the participants may experience low levels of discomfort or embarrassment during the interview process. It was reiterated that this research provided Māori nurses an avenue to voice their lived experiences relating to barriers that they have faced when striving to provide Māori-centred nursing care. However, due to the nature of the research, it was anticipated that participants may articulate explicit or implicit experiences about racism and discrimination. To mitigate this discomfort, it was specified that this project strived to be 'mana-enhancing' with the overarching values of kaupapa Māori. The interview questions, setting and communication modalities aimed to optimise tikanga, mātauranga Māori, and the four articles of Te Tiriti o Waitangi. It was made clear to the participants that they did not need to answer any of the questions if they did not wish to and the interview could cease at any time. Further, access to AUT counselling services was available if required. This option was not taken up by any of the participants.

This project ensured protection by applying mana tangata, as per Te Ara Tika Guidelines (The Pūtaiora Writing Group, 2019), in all interactions between the researcher and participants. This enabled the researcher to provide clear and transparent information where the participant was fully informed, respectfully, about their role, risks, and outcomes of the project. The aim was to mitigate any power imbalance between the researcher and participant. True kaupapa Māori research ensures that all findings should be shared with the participants with the aim of promoting positive change.

Finally, a koha (gift) was provided to each participant to acknowledge their time, effort and input into this project. This was in the form of a fifty-dollar supermarket voucher. Here, manaaki ki te tangata (respecting narratives) was an important aspect of respecting their stories whilst ensuring the process of being hospitable and appreciative.

## 4.12 Conclusion

As evidenced in this chapter, the relationship between critical theory and kaupapa Māori methodology provides a sense of optimism towards the possibility of healing historical discourse. However, this cannot occur without acknowledging the past. Although there are some harsh realities associated with colonisation, it is clear that Indigenous research has the potential to lead towards individual and collective agency whilst pursuing transformational change in the research space. This chapter demonstrates the revitalisation of Māori ways of being, knowing and doing. By embedding a kaupapa Māori philosophy within this research project, drawing upon whakapapa and engaging in whakawhanaungatanga have promoted a strong sense of interconnectivity between all parties involved. Further, it has been paramount to ensure that lived experiences remained central to addressing the research aim and question. Thus, promoting sovereignty over the narratives that have been depicted within this research.

As outlined in this chapter, the tenets of kaupapa Māori research have remained central to the data collection and analysis phases. In the beginning stages of participant recruitment, purposive sampling was successful as it was aligned with the ontological, epistemological and axiological underpinnings of critical theory and kaupapa Māori methodology. With only four participants being interviewed, purposive sampling enabled deep critical analysis of their subjective experiences. Ultimately, I focused on the quality of the raw data, rather than the number of participants. The connection between myself as the researcher and each participant promoted deep and meaningful narratives to be thoroughly explored. This connection was established through whakawhanaungatanga and guided by tikanga principles.

Further, the semi-structured interview questions were related to the aim of the research project. Participants were able to define the interview context where they were conducted via a videotelephony system which was recorded. Videorecording of the interviews enabled the transformation of the raw data by rewatching and relistening each interview multiple times. Thus, promoting full emersion into the dataset. Orthographic transcription was applied and followed specific aspects of Braun and Clarke’s notation system to enhance readability of the transcripts.

Finally, reflexive thematic analysis was employed to identify patterns in meaning and develop themes from the entire dataset. The reflexive aspect included my own subjective views, as the researcher, as part of the analysis. Here, reflexive entries were recorded during significant stages of this process. The final themes were generated from the dataset. They were: (1) He kai kei aku ringa – This theme relates to the attributes that Māori nurses bring to the health space; (2) He waka eke noa – This signifies a collective journey; (3) Whaiwhia te kete mātauranga – This refers to the need for developing and delivering education initiatives to enhance cultural awareness, competency and safety. The following chapter provides insight into the findings from the participant interviews. Such findings will be categorised into each theme as a step closer to answering the research question for this project.

# 5 Chapter Five: Findings

## 5.1 Introduction

This chapter serves as a critical juncture in the exploration of the participant experiences where themes have been deeply unpacked. As we journey through the complex landscape of this research, this chapter offers a compass, helping us navigate through the rich tapestry of data and analysis that has shaped a deeper understanding of the subject.

In this chapter, we will unearth the common threads that have woven their way through the array of data that has been gathered. These themes represent the heart of this investigation, providing a means to organise and comprehend the multifaceted aspects of the topic. The findings presented within these themes will shed light on the research question and wider objectives posed at the outset of this study. Furthermore, they will allow us to draw conclusions, make connections, and offer interpretations, all of which are crucial in contributing to the larger body of knowledge relating to developing strategies to enhance Māori health outcomes in the private surgical setting.

As outlined in the previous chapter, the reflective thematic analysis has led to the generation of three core themes: (1) He kai kei aku ringa – This theme relates to the attributes that Māori nurses bring to the health space; (2) He waka eke noa – This signifies a collective journey; (3) Whaiwhia te kete mātauranga – This refers to the need for developing and delivering education initiatives to enhance cultural awareness and competency. While this chapter aims to highlight the collective perceptions, experiences and narratives of the dataset, many of the findings also draw upon the individual stories of each participant. Therefore, using individual participant quotes has offered several advantages, including maintaining fidelity to the data, providing depth and richness, illustrating the research findings with real-life examples, enhancing credibility, and empowering participants. These quotes bring authenticity and context to the study, making the findings more relatable, engaging, and transparent.

## 5.2 Theme 1: He kai kei aku ringa

The first theme is he kai kei aku ringa. This relates to the attributes that Māori nurses bring to the health space. Manaakitanga, whānau and whanaungatanga were values that all participants emphasised as being key features of their identities. These were weaved throughout their stories and were reflective of their upbringings. Their experiences highlighted the personal-professional intersection that they each brought to their practice. It was clear that worldviews and values were ultimately shaped by their own whānau. When asking about the inception of such worldviews and values, Nurse D responded:

> *Definitely a lot from growing up within my own whānau. So, good communication, listening to each other, taking each other's point of view into consideration when communicating with each other, and just the whole importance of whānau like being the number one support for me and my practice. My whānau have always supported my hopes and goals and dreams, my career choices, my decisions and life. They've really influenced me to become the person that I am today, definitely. And also the community that I live in and the people that I've met along the way because I have that really good, strong foundation of understanding. I'm able to – I think I'm able to effectively communicate with the people around me and make those connections really well (Nurse D).*

Nurse D expressed manaakitanga being embedded in the whānau unit. This influenced how they perceived, behaved and interacted with the world around them. Similarly, Nurse A recognised the value of whānau being an important construct throughout childhood and adolescence. They explained the significance of whānau interactions in relation to the multidimensional contribution that it has on overall health and well-being:

> *You saw the whānau interactions. You saw how if something impacted one element, whether at that age we understood the true underlining meaning it was still something that we witnessed growing up. Um, it was something that, especially my koro (grandfather) installed in us. Like, you know, if something is going wrong, what else is going wrong and um I guess always being open with your kōrero (conversation) with people, but you can't do that if you don't have good relationships (Nurse A).*

With manaakitanga being central to maintaining strong relationships within whānau, participants felt that their ability to apply this in the clinical setting was essential to the patient experience. Nurse B expressed this by referring to Māori patients as being an extension of their own whānau:

> *Manaakitanga, hospitality, is really important as well. Making sure our whānau feel – I think that's the right kupu (word) – um making sure that whānau feel welcome in our service as much as possible. Seeing how important Māori values can be within the work setting as well. Um and it helps with engagement too, I think. But, like you would engage with whānau, with rellies (relatives), that you meet (Nurse B).*

When exploring participant experiences around the concept of whānau, manaakitanga was a natural component that flowed outwardly from their wairua. This enabled the inclusion of patients' whānau without question. One participant shared a story where the hospital implicitly excluded whānau involvement during a patient's admission process. Fortunately, this particular Māori nurse situated themselves within the admission to provide additional support:

> *So, it's about going in and sitting down with her, asking her 'do you want to bring your whānau in'. Like bring them in, sit here with them. If you feel better having them here, then let's do it (Nurse A).*

Other participants felt that it was crucial in the patient experience, within the surgical context, to optimise whānau input as they are central to enhancing patient outcomes:

> *And whānau, I think in general, play a huge part in the care that we provide and so I think, at any opportunity along my context, the surgical continuum, where I'm involved, I try to get whānau involved as well (Nurse B).*

> *Um because I work in a ward setting and anything that involves patient education, any opportunity that I can capture I try to get whānau involved so that I know that when the patient goes home they've got those support systems (Nurse B).*

The accounts expressed by the participants suggest that whānau are equally as important as the patients themselves. Both are inextricably linked and connected. Each nurse within this study suggested that the essence of whānau is intertwined within the nature of our existence, as Māori. Thus, shaping the underlying values within the Māori worldview.

While whānau is a key component to the patient experience, participants further expressed its interconnectivity with hapū and iwi. Recognising whakapapa connections, between the participants and patients/whānau, established the foundation for whanaungatanga – the glue that binds us together. One participant explained that building such vital connections were inherent to their practice:

> *Where they come from, who they're about, understanding who's around you, who's your whānau. I think I take that extra time to just get to know the person and who they are and who they have around them and what's important to them. And I think that's just inherent in*

> *my practice. I do it without even thinking. So, when I think about it now, it's just – I embody it throughout my care (Nurse C).*

Nurse A also articulated that whakawhanaungatanga, the process of building strong relationships, enhances patient and whānau engagement. Therefore, promoting a sense of autonomy and self-determination:

> *I think probably the first and foremost value is um whakawhanaungatanga. You really can't provide any healthcare without that as your main foundation. Um, you know that relationship is essentially the main building block to be able to provide the care, have your patient engage in their care (Nurse A).*

One participant shared a story about non-Māori staff providing culturally unsafe care for a Māori patient and whānau. This particular Māori nurse was notified about a Māori patient who was viewed to be 'difficult' and 'non-compliant' by the clinical team. Unfortunately, the patient struggled to understand the complexity of information that was being launched at her. Her whānau were sitting in the car, and she was isolated in an unfamiliar environment:

> *So, my first approach was to again just sit down with her and start from the basics. I talked about whakawhanaungatanga and it's very hard to build it on the foundation when somebody is already angry at something that's been provided and you're the person to walk in and deal with it. So, it was about sitting down with her, letting her talk, letting her have her support that she needed that she should have had right from the get-go. Starting with 'hey, should we have a cup of tea while we have this kōrero about this?' You know, simple things to show sympathy to build that relationship so she felt safe to have that conversation (Nurse A).*

This account highlights the need for Māori nurses to be involved in care early in the process. It was clear that the entire scenario could have been avoided if whakawhanaungatanga occurred at the start. Another participant expressed that whanaungatanga enhances communication with patients and colleagues. They also recognised that integrating Te Ao Māori into a Westernised infrastructure is complex and often difficult. However, they have used this to their advantage:

> *I think one of the most important values to me is whakawhanaungatanga and being able to communicate really effectively with my patients and the colleagues that I work with, so that we're all on the same page. And I think one of the most important values that I have is being*

> *able to step back and be able to see the world from two different points of view. Te Ao Māori and Te Ao Pākehā (Nurse D).*

What's more, is that mainstream clinical pathways are beginning to incorporate Māori health models such as Te Whare Tapa Whā. Although this is a step in the right direction, this framework cannot be adequately utilised without whakawhanaungatanga as the foundation:

> *But, again, you can't work your way through Te Whare Tapa Whā with your patient if you haven't got your whakawhanaungatanga to start with (Nurse A).*

Participants recognised that being Māori was advantageous in developing relationships and rapport where they were viewed as being approachable:

> *I think it makes me a more (pause) I want to say accessible, but maybe an approachable service provider. I feel like people – and I hope Māori feel like they can be comfortable around me and can feel like they can talk to me, um if they have any concerns (Nurse B).*

> *But personally, trying to develop rapport with our patients as best as I can so that they feel like they can trust me as a service provider (Nurse B).*

> *But I think there's definitely opportunities where I can talk a bit about myself, where I come from, and I've seen patients open up a bit more. Particularly patients who don't know that I'm Māori as well, having that conversation. People will open up a bit more and it's nice. It's really nice (Nurse B).*

There was a sense of valuing identity when participants articulated the natural progression of connecting with patients and whānau. Here, the personal-professional intersection was evident:

> *You know, the way I was brought up with those things. Respect. Whānau (pause) It's in my daily work. It's like thinking of people in that way. I just have this something in me and I think it's because I am Māori. But it's there. How I was brought up with all those things, all those values, is how I would want to look after my patients (Nurse C).*

> *So that's those values, those family values that I, I see every day and I don't actually have to think about it, it just comes out of me actually (Nurse C).*

In addition to participants harnessing shared values to anticipate cultural needs of patients and whānau, they could identify gaps in the system and act accordingly. Each nurse provided accounts of when patients' cultural needs failed to be met at various stages across the surgical continuum. At times, these nurses were called upon by their non-Māori colleagues to act as cultural mediators or brokers. Unfortunately, they were involved late in the piece where they needed to mitigate issues that were deemed culturally unsafe. One participant shared a story about a patient who was feeling isolated and was not given the option for whānau to be present. This participant felt as if this was culturally unsafe and morally unjust:

> *So, it was giving her those options. 'Do you want your whānau around you?' Supporting her to say, 'you need to put a complaint in about this.' She was like 'no no no no no darling I don't wanna be a hōhā (nuisance)' – 'Oh no you're not being a hōhā.' (laughs) You know, like enabling her to have that freedom of speech to speak up, to say there will be no implications on her (Nurse A).*

This account demonstrates the nurse's ability to provide options and enhance a sense of autonomy and self-determination. It was clear that the patient did not want to be a nuisance by submitting a complaint about the experience. However, the participant knew that this was necessary to initiate change and call out institutional racism:

> *'I will be putting in an event report on your behalf, from my perspective not from yours, it makes no difference, you won't be identified...if you still want to go ahead and put that in or you would like support to do that.' I'd given her my card so she can reach me here (Nurse A).*

Strong advocacy and whistleblowing were present in this nurse's practice. Further, they felt it necessary to be involved in on-going care throughout the patient's journey. They remained front and centre to the provision of clinical care whilst also addressing any possible accessibility concerns.

A similar scenario occurred with another participant where they were called in to act as a cultural mediator. This particular Māori patient had been given conflicting information about managing their own wound care when they were back at home. Not only was the information confusing for the patient, but she was also unable to comprehend the complexity of the wound care products, nor did she have any support at home to assist with this. Again, the participant was brought into the event late in the piece where the patient was frustrated and angry. The participant expressed that it was difficult to build a relationship with the patient as there was already a sense of mistrust in the service. However, this Māori nurse engaged in whakawhanaungatanga and created a safe space. They were able to carry out a health literacy assessment, provide information to the patient that met their level of comprehension, and engaged with the patient's whānau over the phone. The participant recognised that this event needed to be reported and advocated for the patient by doing so:

> *I gave her every opportunity to escalate her concerns and her complaints as well. And she wasn't so keen. I think she felt like a bit of a hōhā. That's in her own words. But we do have a process where through our complaint system where we escalate incidents, there's a section or an area where staff can also escalate their concerns on that platform. So, with her consent. I did that on her behalf. But, if I wasn't there, I wonder how it would have gone down. And that concerns me. Um, that really concerns me actually, that it could happen again. And that's, I think, my driving force for us to start reframing and refocusing how we provide care (Nurse B).*

The participant expressed deep concern about the level of care that may not have been provided if they had not been there. In fact, they felt as though the entire situation could have been avoided if they had been involved in the patient's care at the beginning of their surgical journey. Participants also expressed that this is an avoidable dilemma because the private surgical setting is less demanding than public hospitals. This comparison highlights the luxury of time where they can engage in whanaungatanga, build relationships, engage whānau, and tailor culturally appropriate care for their patients:

> *So, being able to take the time. I think that's the plus side of working in a private healthcare setting is that you have the time to care as opposed to working in the public healthcare system where it's overloaded with patients and the demand is a lot higher for your attention, and in private you have only a set number of people that you're going to see in any given 8 to 12 hour time period. And so you're able to spend more time with those people on an individual one to one level which I think is really effective (Nurse D).*

Although this is a positive aspect of nursing in the private surgical setting, such narratives suggest that these settings do not acknowledge the valuable role that Māori nurses play in enhancing holistic care. Participants articulated that Māori patients need to be identified early in the process so that they can be involved in their journey from the start. This may mitigate any culturally unsafe practices along the way whilst providing Māori-centric care. One participant expressed concern about trying to provide holistic care in a short space of time:

> *So, you try and provide as much of a wraparound service as you can, and the care of that patient while you have them, to make sure that they're OK. You do as much as you can because you capture them in only a small snippet of their journey through surgery (Nurse B).*

On the other hand, another nurse shared insight into the need for their cultural expertise being requested by a Māori patient:

> *And so the duty manager came to me and said 'she's asking for a Māori nurse, can you go and talk to her?' So going into that, not really knowing what to expect as well. But again (pause) I was just myself. I sat down with her. I think I spent about like, an hour. Maybe it felt longer, like an hour/hour and a half talking through her concerns. A luxury that I feel like, in the setting that I'm in, I wouldn't have really had otherwise (Nurse B).*

Māori nurses actively try to spend time building meaningful connections. Time that they may not have had if they were working in a public hospital. Participants were confident in speaking up when they anticipated more time was required to provide Māori-centric care that strengthened their ability to adequately cater for individual patient needs:

> *'Look, I'm going to spend a bit more time with this person.' But I knew that she needed the time. I knew that she needed a bit more time to talk through what she needed. And we made a plan. And we identified she had some support, so I made sure she had the right information because we identified she was given incorrect information (Nurse B).*

Although this example demonstrates the positive aspect of time-availability in the private setting, incorrect information was delivered to the patient whereby the Māori nurse needed to rectify this. This reflects the need for cultural advocacy and support throughout the patient journey. However, all participants expressed concerns with having to 'put out fires' due to limited Māori representation and advocacy within their hospitals. They made it clear that they are truly committed to enhancing Māori-centric care:

> *I believe that I can help to make our service more Māori-centred, which is quite a daunting, daunting task, really (Nurse B).*

However, they are practicing in isolation and articulated the need to grow the Māori nursing workforce. When asking one participant why they thought Māori patients and whānau are not receiving culturally appropriate care, they responded:

> *Lack of Māori health workers or the other workers. I've been the sole Māori health care worker here for a long time (Nurse C).*

Another participant responded to the question by sharing their viewpoint about publicly funded contract patients entering private hospitals for surgery when public surgical waitlists are lengthy:

> *I suppose the lack of Māori staff face to face at my hospital. I mean there's only a less than a handful I'd say. And so, for our Māori patients that come through, into a really daunting environment, potentially it could be quite scary and foreign to them especially because a lot of our patients just assume that their surgery is going to be done at just a different hospital, and that's part of maybe a public service and that our level of service is going to be the same as in public, you know, long waiting times or whatever (Nurse D).*
>
> *But, again, because I think the number of Māori staff that work within my hospital is low, it's like a little bit daunting and I think probably if there was more face-to-face interaction with Māori staff members, then our Māori patients would benefit greatly from that (Nurse D).*

In contrast, when asking participants if they've met organisational barriers when attempting to cater for the individual needs of Māori patients and whānau, all except one participant responded that this was a continuous struggle. The participant who did not find this to be an issue within their hospital was a Māori Nurse Manager who replied in a way that was mana-enhancing to their position:

> *No, because I'm actually probably in the position where, you know, I'm a nurse manager. So, staff come to me and will say, what's an example? What is best for or – and that's the whole idea, isn't it, that we want more Māori in management positions. And I said to you at the beginning, there's such a lack of it, of Māori managers. We need more Māori managers because we're in that position where we can make change, and we can push forward, you know (Nurse C).*

In fact, this particular nurse articulated commitment to the Māori nursing student workforce:

> *Historically, why have we only ever gotten non-Māori students here? Since I've been in this position, that has been my drive. I want to know who the Māori student nurses are. And I have that connection with the Polytech because they know this. Because, if I wasn't in this position, no one would be pushing for that. Because I know that they will get really good surgical training, but I also want them to have that Māori world view when they're looking after their patients (Nurse C).*
>
> *And we go to the Polytech, the staff educator and I, to talk to the Māori student group, let them know who we are, where we are. But we've got a lot of work to do in providing them, you know that tikanga Māori – because that's what they're learning in the Polytech. How do they implement that (tikanga Māori) into here, how do we do that here for them? It's a lot of mahi (work) to do and to push through – going to the schools (Nurse C).*

This example highlights the power and influence that Māori nurse leaders have in the workforce development space. Here, the nurse has been successful in building external networks through whakawhanaungatanga to optimise the opportunity to increase the workforce, and inspire young Māori to enter the profession.

Another participant shared that their hospital had allocated them time in their roster to work on Māori health initiatives and provide cultural support as needed. It was clear that their managers and colleagues valued their expertise to enhance Māori health outcomes within their surgical services:

> *I'm probably just really lucky that I work with a great bunch of people that are really open to learning more about my culture and asking me questions about it and understanding it a little bit more (Nurse D).*

### 5.3 Theme 2: He waka eke noa

The second theme is reflected through he waka eke noa. This signifies a collective journey. With the common goal of enhancing Māori interests and improving Māori health outcomes, we must collaborate with others to successfully achieve this. The central organising concept for this theme is based on collaboration and co-design.

When discussing the need for Māori-centric care with the participants in this study, each nurse asserted that Māori are requiring more hospitalisation in the private sector due to extended surgical waiting lists in the public sector and an increase in Accident Compensation Corporation (ACC) contracts. All participants recognised that although Aotearoa New Zealand has a publicly funded healthcare system, disparities in health are an ongoing issue. Nurse D expressed their concern with the growing Māori population entering private services without robust cultural support in the sector to cater for such needs:

> *Historically, the number of Māori that access private healthcare is very minimal. It's increasing but is definitely still quite minimal. The need for Māori cultural support and tautoko (support) Māori has not been there, or has been few and far between for the last however many years. And so, it's only now that the need is increasing because the patients coming from Te Whatu Ora (public sector entity) or ACC, your external agencies, is increasing as well and a lot of the demographic from those areas are Māori patients with who may require the extra cultural support that is currently unavailable within the private sector (Nurse D).*

When exploring participant perceptions about the work that their organisations are undertaking to ensure culturally appropriate care is provided to Māori who engage in their hospital services, all replied with:

> *A work in progress.*

Although this appears to be a promising response, they answered with humour and suggested that such undertakings had been a work in progress for quite some time. Some participants accepted that was legitimate whereby some initiatives were going through different stages of development. Therefore, being optimistic about processes that were continuously evolving:

> *Minimal at present, but I think quite a good plan to improve over the next couple of years (Nurse D).*

> *And then nationally, there's a move towards creating a guideline and a policy for our whole hospital network to be able to refer back to for guidance if required when talking about staffing and education and patient care and the obligations of our hospital organisation (Nurse D).*

One participant thought that the current work that was being carried out was a promising process. However, as they continued to think deeper into their response, their answer was becoming pessimistic in nature:

> *I think it's more of a work in progress if there's nothing solid in place at the moment. But we're doing little things. We're trying to get a whānau room in place. And it's a lot of 'we're trying to do this, we're working towards that at the moment, but to be quite honest, there's nothing that I see as a ward nurse, at the moment, that we're doing specifically for Māori (Nurse B).*
>
> *So again, there's a lot of work to be done in that space, so it's a bit sad that I can't say that I know of things that are actively happening within our hospital that are Māori-centric. But that's the reality, yeah (Nurse B).*

This participant had reflected on previous conversations with hospital leaders about the progress of Māori advancement initiatives. This nurse felt as if their expectations were being managed by such leaders. Thus, ensuring avoidance of premature criticism about the lack of progress.

Further, Nurse A provided an example of expectation-management by their employer. It appeared that their intention was to signal that improvements or changes were on the way and that they should not judge the final outcome based on what they saw at that particular moment:

> *I think in terms of our policy within our local hospital, there's not a lot. We're just, like I said, you've got people that are sitting there saying 'yeah, the policy is we treat them fairly and treat them with the 3P's.' So, there's no real true document or policy, locally, within our hospital. Um, the overarching national ones? Not really a thing. It's a work in progress (Nurse A).*

The presenting issue here, that all participants expressed, is that outdated polices relating to Māori health can be detrimental. To address these concerns, participants highlighted the need to regularly review, update, and adapt their Māori health policies to ensure they are relevant, effective, and responsive to the changing needs and circumstances of Māori communities.

On the other hand, Nurse B was impressed with the collaborative efforts that the Quality team were undertaking with hospital leaders in gathering important data to drive initiatives that would benefit Māori:

> *I know that Quality is looking at data as well. Trying to identify any disparities. Also working in Pacifica as well, which is another story. Whether that be with infections, falls. I've seen work being done with that, but with the hopes of maybe using that data, somehow, to make an improvement (Nurse B).*

Additionally, this participant has been working with their hospital Quality and Risk manager in gathering Māori patient-experience feedback. Participants recognised that this is a fundamental step towards achieving culturally competent, equitable, and patient-centred healthcare services. It helps identify areas for improvement, ensures cultural responsiveness, and fosters trust between healthcare providers and Māori communities, ultimately leading to better health outcomes:

> *All I know is that through my work in Quality, I see feedback from our Māori patients and the feedback is generally good. We don't get a lot of, or if any, negative feedback. We're looking at how we might – there's a response rate for our feedback process for patients, post-op, is relatively low. For Māori, specifically, I'm not too sure what the numbers are. So, I don't know if we're capturing, or if patients are really getting back to us, or all of them, or the vast majority to be able to say that everyone is happy with their care (Nurse B).*

While it is imperative to gather Māori patient feedback about their hospital experiences, this quote suggests that engagement with the process is low for Māori patients. Given the Westernised infrastructure of the health system, it is questionable whether or not their data collection methods are suited to Māori.

Participants understood the power of data collection in the context of improving Māori health outcomes in their settings. They felt that data from Māori patient feedback should be explored and analysed collectively between Māori and non-Māori within their organisations. This triggered some participants to work with the Quality and Risk managers within their hospitals to form Māori Health Committees:

> *Um we do have a Hauora Māori health committee that we formed last year and there are only a few Māori on the committee, and so we're trying to work towards forming relationships and that's been quite a slow process as well. We need to do better, and I think that'll come from higher up as well. But to be quite honest, being one of the only Māori who are in the committee – I'm not from this area. I don't already have existing connections like*

> *other people may have. It's been a challenge. But I would love to have more Māori at our hospital (Nurse B).*

While some participants highlighted the achievement of being part of such committees, their groups mostly consisted of non-Māori. Participants who did not have established Māori Health Committees at their hospitals still managed to connect, nationally, with other Māori nurses within the private sector. Participants urged the need to collaborate and unite their efforts to bridge the gaps in healthcare disparities that disproportionately affect their people. They recognised the need for a collective approach to draw upon their unique cultural insights and their deep understanding of the challenges faced by Māori patients and whānau.

What's more, is that participants understood that there is a negative perception of private hospitals amongst the Māori population:

> *One thing, too, out in the community when I talk to random people or patients, they talk about private hospitals, and this is only for the rich people and it's only for those who can afford to. People have this perception about private hospitals being only for those who can afford. Right? But that's not true. We now offer a service that, you know, for the public system and for ACC. We have the means, we have the rooms, we have the theatres so that people aren't waiting. So as a private hospital, I think we're trying to help the community (Nurse C).*

Nurse A suggested that there are underlying factors contributing to suboptimal engagement between Māori and private hospitals. It appears that the private sector has failed to connect with Māori communities to understand the reasoning behind this issue. The public sector has successfully connected with Māori communities and have taken a 'deep dive' approach into what complexities are at hand. Thus, collaboratively developing strategies to tailor health services to the needs of the Māori population:

> *Actually, getting to the bottom of why these patients aren't coming because there is often a very good reason. And those are the underlying things that get to the bottom of the issue. Ask Māori what the Māori want. Ask them yourself what the issue is. Get to the bottom of it and find a solution TOGETHER driven by them. And I think that's where some of these initiatives coming out of our local public hospital is starting to address that stuff. But again, we sit in a region where we have a high Māori population, and the Māori Health Board sitting there covers three major iwi and they are all very strong in advocating (Nurse A).*

Nurse D's perception was much the same where they urged the need for private hospitals to explore specific areas where disparities may be exacerbated by the current health infrastructure to enable targeted interventions to address such gaps:

> *I think the level of support for Māori patients and their whānau in public is way better than in private, currently. But the potential is there for the private hospitals. I'm unsure, obviously outside of my own hospital and network, what other services might provide and I'm well aware that there are multiple private hospital companies that operate within Aotearoa that aren't necessarily all on the same level or understanding or requirement (Nurse D).*

Nurse B recognised that this approach would help identify areas where hospitals can enhance their services, streamline processes, and address shortcomings in care, ultimately leading to better healthcare outcomes for Māori. They linked this approach to the development of quality models of care:

> *But I think we need a better model of health to guide us through the care of our patients, and part of that too, is making sure that we have the resources and the support for that patient throughout the continuation of their care while they're with us, and again as I mentioned earlier, have better post-op follow up with them as well (Nurse B).*

When asking participants about the level of priority they thought their hospitals placed on connecting with Māori communities, Nurse C shared an insightful viewpoint:

> *I don't think it's a priority. They're very open to doing better and to providing what we need (Nurse C).*

> *We're not doing that: wrap around services...wrap around services – you know, it's been all about patients in and patients out (Nurse C).*

All participants suggested that this may be due to a lack of cultural understanding and Māori consultation at organisational leadership levels:

> *Um (pause) I feel the entire organisation actually lacks Māori representation at the top level with the executive leadership team, and (pause) possibly lacking a wee bit within the*

> *Board as well. And it's very hard to drive change in a large organisation from the bottom up if you don't have to support from the top down. There's no meeting in the middle to come to a partnership on creating those relationships (Nurse A).*

Nurse A explained that this has led to a misalignment between organisational values and the required output to enhance Māori health outcomes:

> *But when it comes to the organisation, they have a huge responsibility to be making sure that stuff is there to improve what education, guidelines, basic standard of care that we are providing. If you've got a motto of your company that says we strive for the best, then actually make it the best (Nurse A).*

Participants expressed the need for strong leadership, along with Māori consultation, as being essential in improving Māori health outcomes and experiences because it drives systemic change, advocates for Māori rights, ensures cultural sensitivity, and addresses the complex web of social, economic, and historical factors that contribute to health disparities within the Māori population:

> *But I think we have room to make change and it's not by any means going to be an easy battle. But I think if you've got the right people, the right strong people at the helm that aren't easily broken or easily deterred to push forward (Nurse A).*

One participant, who works within a large private enterprise where processes are developed and guided by a national team, felt that there is a need for robust Māori representation at a national level to ensure a 'trickle-down' effect. This will also promote relationship-building with external stakeholders:

> *I think it would be helpful if, at a national level, there was support and drive that would follow and trickle down to us as well. I think if there was more of a relationship with local support services and with iwi, therefore hapū and whānau. I think that would help us at a local level and to be able to form a better relationship, and that would be across the board, not just at the site that I work at, but also all of the other sites within my region (Nurse B).*

Unfortunately, participants felt as if the responsibility of forming connections with their local Te Whatu Ora hospitals and iwi was their sole obligation as Māori nurses. There was a true element of 'cultural loading' evident within their narratives. One participant felt that there was an immense amount of pressure to do so, and was uncomfortable with this responsibility as they were currently on their own cultural journey:

> *But I didn't grow up on the marae and I'm very much an urban Māori and that I grew up close enough to my marae where I have a connection, but if I were to go there, people may not know who I am. So, I think that contributes to a lack of confidence and I don't speak the reo as well. So, it's like 'who am I to come into this service and be like this is the way things need to be done' when I'm no authority on things tikanga and kaupapa Māori (Nurse B).*
>
> *And have a stronger relationship with local iwi, and who know the community better than I do. Because I don't have any pre-existing relationships either with services or with the locals. Um, so I feel like a bit of an outsider in that space (Nurse B).*

Nurse D's perception of 'cultural loading' was unsafe. They further endorsed the necessity for Māori leadership as a safe support requirement:

> *And if there isn't that level of support then that can be really daunting for Māori staff to be working in such a foreign environment, especially when we don't have – within like our private hospital network, we don't have that Māori health team as such. There's no like – in public they have Māori health support services and you don't have that in a private setting. So, where do you go to for help? I think that, as an organisation, they could obviously first of all increase the number of Māori in leadership positions so that there are people to look up to and go to for advice or support when you need it. Is probably the first step. Increasing Māori into leadership positions, leading to the increase of Māori on the floor so that our patients are face to face with Māori health professionals would be great (Nurse D).*

As participants admitted that their hospitals lacked Māori patient support, they felt burdened to deliver this service in isolation. They recognised the need to form connections with Te Whatu Ora and their local iwi to either provide such services or collaborate and co-design a framework within their own settings:

> *There's lots of room for improvement. Yeah, there isn't – There aren't any, that I'm aware of, any existing relationships with kaupapa Māori services, and there's certainly no in-house services that we can provide. But I think at a local level we're trying to make small gains and small progress towards trying to link up with local DHBs [District Health Boards, now known as Te Whatu Ora] (Nurse B).*

> *I can't link the patients up with kaupapa Māori services – we don't have in house or external Māori health services or providers that we have relationships with. So, I can't tell them 'here, if you need support, call these people' or I can't just ring someone up and say 'can you come and see this patient?' We don't have Kaumātua that we can ring to do karakia, although there are people in the hospital that could probably accommodate. We don't have an in-house team for Māori support services. I would love that, ideally. Or at least a person or people. And that's, I think, something that's missing within our service? But I would like to see our whole service embracing kaupapa Māori anyway, so that it doesn't matter who you are, necessarily. You can provide for a patient's needs and Māori patients' needs. But there are times where I think someone who is Māori and who works in a predominantly kaupapa Māori space and in that mindset. I think we need someone or people like that to work within our service that we can utilise when we need them, which is all the time (Nurse B).*

From an organisational collective perspective, one participant highlighted that there were other Māori nurses employed within their organisation. Albeit, spread across multiple sites. They were positive about the thought of connecting and collaborating on a national scale to develop a network of support staff that could collectively develop a framework to support Māori patients and whānau:

> *We're all captured where there are a lot of iwi and hapū that we need to consider. But I feel like that can't just come from us as individuals. I think if we work together at the different sites and form a relationship as an organisation, as opposed just at a local level, I think we can – I think that is the ideal (Nurse B).*

Additionally, participants were concerned with the fact that their services often received Māori patients from multiple geographical locations. Due to the large demographic that their hospitals covered, there were socioeconomic factors that were not being considered or addressed. Transport, accommodation, food, time off work, and other associated costs appeared to have further contributed to disparity. There was also a lack of cohesion and communication amongst health providers across regions:

> *I've had examples over the years where we have, like I said, we have a lot of rural areas around us and we have the contracts that are able to do surgical procedures for the patients, for the Māori in our area that come under the public system. Which is a great thing. We have the facilities; we are able to help the community. But we can do better*

> *because – I was talking about the rural areas, it's often hard to get people on the phone in rural areas, for example. So, making those connections with the local GPs (General Practitioners), the district nurses, or the nurses that work out of the GP offices. It's just hard. The communication, the connection (Nurse C).*

Nurse C highlighted the impact that this has had on the whānau unit:

> *They come from a rural area, they don't know where are they going to stay in town. What can we do there? We can certainly have one person staying overnight to help with, but we don't work like that. Māori don't work like that: one person coming with them. So, we don't have anything like that in the facility. We did have a whānau room and that was disbanded and taken away from us for reasons of, you know, needing the room to for an extra patient room type of thing. So, we haven't got that (Nurse C).*
>
> In addition to a lack of whānau rooms at the participants' hospitals, whānau are expected to source and pay for their own accommodation. While most private hospitals may allow one whānau member to stay overnight, sleeping in an armchair, there is also cost associated with this.

### 5.4 Theme 3: Whaiwhia te kete mātauranga

The third theme is whaiwhia te kete mātauranga. It is about understanding current education initiatives and where there are gaps. The central organising concept for this theme is based on a journey towards cultural awareness and competency. This theme enables the exploration of patient experiences articulated by the participants, employing multiple learning modalities, and the pursuit of equity, self-determination and autonomy for Māori.

When exploring participant perceptions of their organisations' commitment to education around cultural awareness and cultural competency, there were a mixture of responses. Nurse D felt as though their hospital was committed to this process where the end result was to improve Māori patient experiences:

> *I would say that the organisation that I work for is – especially within my own hospital, are really supportive of the idea of increasing cultural awareness, cultural competency, and the support that we give our Māori patients. They understand the importance of it and*

> *understand that it's not just about ticking boxes. That it's actually about doing the work. And I think that there's great potential there, definitely. But it's still most definitely in its infantile stage, like very developmental at the minute (Nurse D).*

Although Nurse D's organisation was early in their journey towards achieving cultural competence and safety, the implementation of online education has greatly benefited knowledge acquisition for the staff. With the support of organisational leaders, the roll out of the education has been well-received:

> *There's been an increase in the number of online education packages that staff have been required to do in the last year that educate around those topics. There's been lots of communication from higher ups to the staff to help them understand a little bit more about the changes that are being made within our organisation (Nurse D).*
>
> *But the most recent one that we've done was really good. I think the feedback that I heard, once we had started completing it, was that people were enjoying it. And I think that it's helped improve the understanding of our culture and practices, tikanga and stuff like that as well as just being another thing that people have to complete tick boxes for work. I also feel like there's been just an increase in the number of mandatory online things that we've had to do (Nurse D).*

While Nurse D's organisation appear to have established an initial education initiative to enhance cultural competency, Nurse B highlighted a similar experience within their hospital:

> *I don't know of any strategies, but I know that we have – for new employees, we have education and training, we have annual updates as well for Te Tiriti and cultural competence training and unconscious bias training as well as part of our annual updates (Nurse B).*

Further, other participants stated that their organisations had also adopted similar learning opportunities. However, it was questionable as to the authenticity and motivation of the organisation's reasoning for implementing such education:

> *Um, we have – Our organisation, nationwide, has those learning modules. But it's very broad. I think that's again a tick box. That's a requirement that once you've got that off your mandatory list, that's basically it (Nurse C).*

Other participants also felt that these education modules were a 'tick-box' exercise where hospitals are required to demonstrate compliance of staff engagement in such mandatory learning:

> *I wouldn't say it's a huge amount. There is the compulsory online stuff when people first start (employment). There was the compulsory online learning module that was needed to be done with regards to Ngā Paerewa. And outside of that I would not say there is a huge amount (Nurse A).*

Participants recognised that hospitals must offer education on the Ngā Paerewa Health and Disability Services Standard to ensure compliance with these guidelines, improve patient safety and care quality, enhance staff accountability, promote cultural competency, and uphold legal and ethical standards. Participants argued that staff engagement with such education was often limited as many did not understand the importance of cultural competency education specific to Māori health outcomes. Although these are mandatory requirements, it appeared that there was a lack of willingness for staff to engage:

> *Our educator spends a lot of time chasing people up, trying to get them to do it. There's constant extension dates put on when this stuff is due by, but I don't think it's anywhere near given the value or any level of importance that it actually warrants (Nurse A).*

One participant provided an example that highlights the reality that many nurses are not actually absorbing information from the online education modules covering Te Tiriti o Waitangi, Ngā Paerewa Health and Disability Services Standard and cultural safety:

> *But you know, I work with a colleague that still goes on about the 3P's and I'm like 'oh God' and I was writing competencies the other day where she wrote THE TREATY OF WAITANGI, and Ngā Paerewa not even spelt right, and I'm just going 'where do I begin with that?' (laughs) I think there's a lot of self-responsibility, individual responsibility, organisational responsibility, and actually national responsibility (Nurse A).*

Participants acknowledged that the reluctance to engage in Māori health education may have stemmed from various factors, including cultural differences, limited awareness of the Māori worldview, and systemic barriers within their organisations. Cultural differences have created discomfort or uncertainty for nurses, making them hesitant to broach sensitive topics related to Māori health. Participants stated a lack of knowledge about Māori culture may have resulted in unintentional insensitivity or misunderstanding. Historical systemic organisational issues have also hindered nurses' willingness to engage effectively in Māori health education. Unfortunately, this has impacted on patient and whānau experiences and outcomes.

One participant shared a sobering experience of a Māori patient who had come from a different region of the country for her surgery. Her family were made to feel unwelcome, and she struggled to understand medical terminology or what to expect from her procedure. When she tried to seek clarity from the non-Māori medical and nursing staff, her queries were met with hostility and impatience. When Nurse A met with the patient, the discussion was confronting:

> *Her first question was 'is this because I'm Māori so it doesn't matter?' That's a pretty embarrassing conversation. To sit there (pause) and have to say 'no it has nothing to do with that.' And then it's like well 'is it because I'm ACC so it doesn't matter, I'm not paying' (Nurse A).*

Nurse A made sure to follow the patient through their surgical journey to ensure advocacy and support was provided. The participant highlighted that this a prime example of cultural incompetence whereby organisations are not providing relevant training and staff are lacking engagement:

> *But the lack of understanding because you have a half-arsed education (laughs) around thinking about that stuff. It's not considered. There's no thought to tikanga and having whānau support there. Something as simple as that (Nurse A).*

This demonstrates that there needs to be individual and organisational accountability here. Challenges have arisen due to a lack of cultural awareness, resources, time constraints, and varying levels of training among healthcare professionals. All participants urged the need for health practitioners to be emersed in historical education around Te Ao Māori, mātauranga Māori, colonisation, Te Tiriti o Waitangi, cultural and political discourse, and tikanga practice:

> *Looking back at all the years of injustices, and things like that, that have happened (pause) I think there's still so much misunderstanding about that foundation stuff and if you don't understand history and where people have come from, and why they are disadvantaged (Nurse A).*

Participants recognised the need for health staff to understand the ‘why’ that underpins cultural competency education regarding Māori health:

> *And education I think, definitely, it all just comes back to education for our current staff, understanding the importance of what we're doing, why we're doing it and formulating plans based on real time information. And at the same time, increase the level of understanding that our staff have, and I think that that's really important to be able to gain that health equity and understanding for our people (Nurse D).*

> *If you don't understand that, you're not going to change are you? Because you don't change what you don't understand. So, I think there's responsibility everywhere across the board (Nurse A).*

It was clear that education and awareness needed to be embedded across the entirety of their organisations. Particularly, starting from the highest level of leadership. One participant provided a confronting account of having to put a business proposal together to fight for a whānau space to be implemented at their hospital:

> *I've recently done a business proposal to have one of the in-patient rooms changed into a whānau space, and what's guided us through that process is (pause) Māori beliefs and values that I think are important to consider with the use of the space, changing policy as well to help protect the use of that space (Nurse B).*

Although public hospitals are well-equipped with whānau spaces, these are lacking in the private sector. All participants stated that each of their hospitals did not have an allocated whānau space. Based on Nurse B’s requirement to complete a business case, they needed to articulate that whānau spaces foster a healing environment that recognises the holistic nature of Māori health and well-being, acknowledging that physical healing is intertwined with spiritual and emotional aspects. The whānau room not only supports better health outcomes but also helps in preserving and celebrating culture and identity within the healthcare setting, ultimately contributing to a more inclusive and patient-centred approach to care. The participant suggested that a business case probably would not have been required if only their hospital leaders had the cultural awareness and competence to understand the significance that this has on improving Māori health outcomes.

As all participants expressed that their hospitals are engaged with mandatory online education modules, it appears that there is an element of stagnation, a lack of continuation, and limited variety of learning modalities:

> *There's no reiteration, there's no follow up, there's no ongoing training, and it's pretty basic and I'm pretty sure it's outsourced to an external source (Nurse A).*
>
> *So, it's not even an on-site training where you could sit around and talk with nurses, or doctors and surgeons, or um anybody really, to say you know (pause) 'here's a case, study let's talk through it', how could this – you know, there's no training, there's no personable training, put it like that (Nurse A).*

Participants suggested that the format of online courses, often consisting of text-heavy modules or pre-recorded lectures, may not effectively engage learners in a way that promotes active learning and retention. Additionally, the demanding and fast-paced nature of the nursing profession can make it challenging for them to allocate sufficient time for in-depth cultural competency training. Further, participants urged the need for multiple learning opportunities that provide continuous development and growth:

> *To my knowledge, there's nothing else going on throughout the year to promote mātauranga Māori, or opportunities aren't actively offered to staff members that I'm aware of. Or even as part of our process to make sure that staff maintain a level of understanding around mātauranga Māori, or anything kaupapa Māori is pretty minimal. I think we need to have better cultural training as well with this cultural competence. And whether that's a trip to the marae so that people have a good understanding of our culture, or some understanding of our culture. I feel like a lot of nurses don't have that experience or haven't had that experience (Nurse B).*

Moreover, the absence of real-life interactions and hands-on experiences in online courses can hinder the development of practical skills needed for culturally sensitive patient care. Participants suggested that cultural competence is best cultivated through continuous exposure and real-world practice, which may be insufficiently addressed in isolated online modules. A blended approach, combining online learning with in-person workshops and patient interactions, may help health professionals to better absorb and apply cultural competency knowledge.

## 5.5 Conclusion

In conclusion, this chapter has provided a comprehensive exploration of the key themes and significant findings that have emerged from the research. Throughout this chapter, we have delved into the attributes that Māori nurses bring to the health space, the need to collaborate and co-design to enhance Māori health outcomes through a collective approach, and develop and deliver education initiatives to enhance cultural awareness and competency.

Upon investigating the first theme, he kai kei aku ringa, it was evident that the attributes that Māori nurses bring to clinical practice are born out of the values shaped by Te Ao Māori and mātauranga Māori. These were developed during the participants' upbringings. Manaakitanga, whānau and whakawhanaungatanga underpin the way in which Māori nurses view the world. The participants had harnessed these values where the personal-professional intersection enabled advocacy for moral and cultural justice. Although their organisations valued such attributes, the findings highlight the need to commit to further growing the Māori nursing workforce, invest in the development of current Māori nurses, and develop strategies to minimise cultural loading in the clinical setting.

When exploring the second theme, he waka eke noa, it was clear that the private sector is somewhat disconnected from the public sector and iwi. Further, participants expressed concern with the lack of Māori governance within their organisations. This has resulted in the continuation of Western approaches to Indigenous health. Thus, resulting in adverse Māori patient outcomes and placing significant pressure on Māori nurses. Participants made it clear that it is not sustainable or culturally safe to function in isolation. They urged the need for private hospitals to establish relationships with Te Whatu Ora, Te Aka Whai Ora, iwi and Māori health providers for the purposes of collaborating, co-designing and restructuring surgical services that benefit Māori patients and whānau.

The final theme, whaiwhia te kete mātauranga, highlighted the need for private hospitals to develop and deliver education initiatives that enhance cultural awareness and competency. In fact, it is the current priority as cultural competence and safety ensures all organisational processes are developed in a way that is underpinned by Te Tiriti o Waitangi, Te Ao Māori and mātauranga Māori. It was clear that online modules, as a single learning modality, have not optimised cultural competency or safety. Therefore, patients and whānau have continued to experience the associated negative effects. This theme highlighted the need for urgent action in developing and delivering education in various formats that are updated, accurate and conducive to achieving positive outcomes for Māori who engage in private surgical services.

As we reflect on the themes and findings presented in this chapter, it is evident that much work is required to enhance the perceptions, experiences and outcomes for Māori. The implications of these themes and findings extend beyond the scope of this research and have the potential to inform change in private surgical settings.

# 6 Chapter Six: Discussion

## 6.1 Introduction

This chapter delves into the intricate relationship between Māori values and nursing practices within the context of private healthcare settings. It sheds light on how the integration of cultural values profoundly impacts the care of Māori patients, emphasising a whānau-centred approach and fostering cultural safety. While the autoethnography and findings chapters exposed the lived experiences and perceptions of Māori nurses regarding the value of Te Ao Māori, collaboration, and cultural awareness in the private surgical setting, this chapter provides a deeper analysis of the findings informed by a strong evidence base.

In healthcare, the profound contribution of Māori nurses transcends conventional roles and is deeply rooted in cultural principles intrinsic to Māori heritage. This chapter illuminates the significance of these nurses, exploring how our roles embody manaakitanga, whānau, and whanaungatanga - concepts that echo the interconnectedness within the Māori creation narrative. Manaakitanga, representing hospitality and respect, serves as a cornerstone for Māori caregiving, intertwining with the notions of whānau and whanaungatanga, emphasising communal connectivity. These core values resonate deeply with the Māori creation story, highlighting the interconnectedness of all life forms and the importance of relationships in sustaining life.

Although the findings highlight efforts to achieve cultural competency through the delivery of Te Ao Māori education, Māori patient and whānau outcomes remain suboptimal, signalling the need for a shift towards cultural safety rather than mere competency. This chapter proposes a transformative approach by advocating for a comprehensive overhaul of healthcare education, workforce development strategies, inclusive leadership models, collaborative co-design processes, and rigorous application of the Critical Tiriti Analysis framework.

By evaluating the strengths, limitations, and implications of these strategies, this chapter underlines the critical role of Māori nurses and advocates for culturally safe healthcare practices to enhance the health well-being of Māori patients and their communities.

## 6.2 Interpretation of Findings

### 6.2.1 The Value of Māori Nurses

A key feature from the findings is the personal-professional intersection that enabled participants to embed Māori values into their practice. Māori nurses' integration of cultural values within their professional roles significantly impacts the clinical setting and Māori patient outcomes. Rooted in their heritage, these nurses bring a profound understanding of Māori values and customs, emphasising a whānau-centred approach that acknowledges the importance of whānau in care. By prioritising cultural safety, they create an inclusive environment where Māori patients feel respected, fostering trust and rapport. Incorporating tikanga Māori practices ensures cultural appropriateness, while advocacy efforts empower patients and promote their voices within healthcare systems. This amalgamation of personal and professional values cultivates a culturally safe space, enhances patient-nurse relationships, and addresses the holistic needs of Māori patients and whānau, positively influencing their health outcomes and experiences in healthcare.

Manaakitanga, whānau and whanaungatanga were recurring concepts that underpinned clinical practice for the participants. While these concepts have been explained in detail in previous chapters, they are inextricably linked to the Māori creation story. Thus, a true reflection of Te Ao Māori. The story of Ranginui, the sky father, and Papatūānuku the earth mother, is integral to the creation narrative for our people and holds deep cultural and spiritual significance. Ranginui and Papatūānuku were originally locked in a tight embrace, resulting in a world of darkness where their children were trapped between them (Warren et al., 2021). These children, the gods, felt confined and sought to create space and light (Reilly, 2018). Tāne Mahuta, one of their sons, separated his parents in an effort to bring light and space to the world (Warren et al., 2021). He pushed Ranginui up high, creating the sky above, while Papatūānuku remained below, forming the earth (Reilly, 2018). This separation brought forth light and life to the world. The story of Ranginui and Papatūānuku reflects the interconnectedness of all living things and the balance between the celestial and earthly realms. It signifies the bond between the spiritual and physical worlds, emphasising the importance of harmony, balance, and connection between humans and the natural environment (Reilly, 2018). These figures hold deep cultural significance, embodying the Māori worldview, traditional knowledge, and the ongoing connection to the land and the cosmos. This story frames the birth of manaakitanga, whānau and whanaungatanga.

Manaakitanga encompasses the values of hospitality, kindness, and care for others (Rolleston et al., 2022). When Ranginui and Papatūānuku were locked in their eternal embrace, their children felt confined between their parents. The act of separating Ranginui and Papatūānuku was not just a physical division but also an act of care and liberation for all existence (Reilly, 2018). It illustrates the importance of recognising the well-being and needs of others. The gods and their offspring became the ancestors of different aspects of the natural world and humanity. This ancestry forms the intricate web of relationships, making all living beings part of a larger whānau (Warren et al., 2021). The interconnectedness and interdependence among these divine beings, nature, and humanity reflect the idea that all entities are part of one extended whānau, sharing common ancestry and responsibilities (Reilly, 2018). This sense of belonging and unity emphasises the significance of collective responsibility and support within the community. This is where whanaungatanga embodies the essence of relationships, connections, and kinship ties (Rolleston et al., 2022). It highlights the importance of maintaining and nurturing relationships within the community. Whanaungatanga stresses the concept that we are connected through shared experiences, ancestry, and interactions. Therefore, enacting mutual respect, understanding, and reciprocity as essential values for building and sustaining meaningful relationships within the broader whānau, promoting harmony and unity among all. As evidenced in the findings chapter, these qualities and values were clearly cultivated by the participants' upbringings. Such foundational principles, forming a personal-professional intersection, empowered the participants to advocate for moral and cultural justice.

Because Māori are a colonised population, it has been an historical struggle to re-indigenise health and well-being since the 1800s. Fast-forward nearly 200 years, Māori continue to suffer health injustices and unfairness relating to equitable health outcomes (Chalmers, 2020) at the hands of the Crown. However, this research has enabled a sense of transformative realisation as it highlights the crucial role that Māori nurses play in improving Māori health outcomes and experiences. By drawing upon the paradox of cultural and clinical expertise, the participants in this study showcased their ability to provide a sense of healing informed by Te Ao Māori and mātauranga Māori. Hunter (2019) endorses this notion by explaining that Māori patients and whānau thrive in health settings where Māori worldviews and models are applied. The personal-professional intersection, otherwise known as 'the hybrid of Indigenous and clinical intelligence' (Komene et al., 2023) enables Māori nurses to draw upon the shared values of manaakitanga, whānau and whanaungatanga, to promote mana-enhancing patient care in private surgical settings. Without this collective process within the nurse-patient/whānau relationship, hauora and wairua are heavily compromised (Hunter, 2019).

As demonstrated in the findings chapter, participants embraced these values which profoundly informed their practice. It was evident that these had a positive effect on Māori patient and whānau outcomes and experiences. Thus, further showcasing the undeniable attributes that Māori nurses bring to the surgical setting within private hospitals. In highlighting this idea, a key concern that came through the dataset was cultural loading. Cultural loading refers to the expectation or pressure placed on participants to serve as cultural representatives or intermediaries within healthcare settings due to their Māori heritage (Komene et al., 2023). While honouring and integrating cultural practices and perspectives is valuable, excessive cultural loading can have detrimental effects on Māori nurses. All participants were continuously called upon to provide their Indigenous expertise over and above their current roles. On several occasions, they were required to 'put out fires' where they had to mitigate situations where Māori patients/whānau were placed in culturally unsafe situations or were not included in aspects of their care pathways. Despite their success in mitigating each event and alleviating situations, there were some underlying complexities that participants implicitly or explicitly described. The emotional burden and professional expectation that came with cultural loading was evident. Here, Māori nurses often feel emotionally burdened by the responsibility of representing their culture where they experienced stress, anxiety, or feelings of inadequacy when expected to be the cultural authority or mediator in patient care, or were continuously needing to educate their colleagues on culturally safe practices (Komene et al., 2023). Other healthcare professionals relied heavily on Māori nurses to bridge cultural gaps, leading to inequitable distribution of responsibilities and an unequal workload. Continuous cultural loading can lead to burnout as it adds to their workload and emotional strain (Komene et al., 2023). Māori nurses feel overwhelmed by the constant demand to navigate between their cultural obligations and professional responsibilities. The participants in this study were clear that cultural loading occurred due to a lack of Māori nurses within their hospitals.

### 6.2.2 Lack of Collaboration and Co-design

Historically, private hospitals have struggled to engage and collaborate with Māori. All participants highlighted a clear disconnect between the public sector and private sector, private hospitals and iwi/hapū, and private organisations and Māori health providers. Reflecting this widening gap, this research shows a lack of Māori governance, decision-making, self-determination and Indigenous ways of 'knowing' and 'being' within private surgical settings. In essence, private healthcare processes have not followed the appropriate tikanga of engaging Māori in initiatives that affect Māori. This Westernised approach to Indigenous health has resulted in unsustainable hauora Māori initiatives.

Participants highlighted that a significant barrier to collaboration is insufficient understanding of Māori culture, values, and traditional health practices within private hospitals. This lack of cultural competence hampers the development of initiatives that resonate with Māori communities, hindering effective collaboration (McLachlan et al., 2022). Further, the participants in this study recognised that this may have contributed to private hospitals prioritisation of initiatives or resource allocation in ways that differ from public healthcare institutions. Each participant knew that the public sector, in comparison to private healthcare organisations, was well-resourced with Māori health support structures and expertise. They were concerned at the lack of emphasis on Māori-specific health initiatives within their own hospitals. It was perceived that the public sector may be miles ahead of the private sector in this respect. Arguably, much of this may still be linked to centuries of colonisation and systemic inequities which have created deep-seated disparities in healthcare for Māori communities. This historical context has fostered distrust between Māori communities and healthcare institutions, complicating collaboration efforts due to existing power dynamics and trust deficits (McLachlan et al., 2022). Unequal representation and power imbalance limits involvement of Māori voices in co-designing initiatives. This exclusionary approach that appears to still be evident in private settings has resulted in initiatives that often fail to address the specific health needs or preferences of Māori patients and whānau (Rolleston et al., 2022).

Furthermore, the underrepresentation of Māori in health policy and decision-making roles has impeded the formulation and implementation of policies (Came et al., 2023) that adequately address the specific health needs and concerns of the Māori population in healthcare. Within the private surgical setting, participants suggested that this lack of representation perpetuates systemic biases and contributes to the persistence of healthcare disparities. Across the health sector as a whole, efforts have been made in recent years to address these disparities through initiatives aimed at improving cultural competency in healthcare, increasing Māori representation in decision-making, and prioritising Māori health and well-being (Chalmers, 2020). However, achieving equitable healthcare outcomes for Māori requires sustained commitment, culturally responsive policies, and meaningful engagement with Māori (Hunter & Cook, 2020). With the release of the WAI 2575 report, the Waitangi Tribunal's conclusions and suggestions regarding policy development, reviews and reforms stem from the belief that policy decisions aren't devoid of ideology (Came et al., 2023). Policy is shaped by the prevailing culture and involves negotiations among various stakeholders. For fairness and justice in policymaking, it is essential to incorporate Māori aspirations, values, and knowledge throughout the policy process (Hunter & Cook, 2020).

As explored in the literature review of this thesis, healthcare policy processes have utilised the English version of the Treaty of Waitangi and its guiding principles established by executive and judicial branches. This preference reinforced the government's claim that Māori surrendered sovereignty to the British Crown, a stance the tribunal opposed in 2014 (Berghan et al., 2017). Prioritising the English version over the Māori text disregards the fact that most rangatira (chiefs) signed the Māori text (Came et al., 2020). According to the international legal doctrine of contra proferentem, during disputes, the instrument should be interpreted against the drafting party, in this case, favouring the Māori text (Came et al., 2023). This bias justifies a limited acknowledgment of genuine Māori representation and authority in policymaking, restricting Māori autonomy in their affairs (Huria et al., 2014). Conversely, privileging the Māori text and rejecting the notion of cession of sovereignty alters the political landscape. It establishes Māori, as citizens, as stakeholders in sovereignty while holding an independent authority that deserves recognition in policies and guidelines.

If we consider Te Tiriti o Waitangi, in the context of a lack of collaboration and co-design, evidence from the findings highlight several breaches. The lack of collaboration breaches kāwanatanga by not respecting Māori governance and authority in healthcare matters. It perpetuates an historical pattern where decision-making power remains with non-Māori entities, disregarding the intended partnership outlined in Te Tiriti (Berghan et al., 2017). With regards to tino rangatiratanga, the absence of collaboration denies Māori the opportunity to exercise their sovereignty in healthcare decision-making. It reinforces a system where external entities hold the power, limiting Māori their right to determine what health initiatives align best with their cultural beliefs and needs (Came et al., 2020). Without active participation in designing such initiatives, Māori are denied equitable access to culturally appropriate healthcare, leading to further disparities and unequal health outcomes. Thus, limiting the promotion of ōritetanga. By omitting the delivery of culturally appropriate healthcare, the system undermines wairuatanga by disregarding the spiritual and cultural dimensions of Māori health (Berghan et al., 2017). Without involvement in co-designing initiatives, Māori beliefs, healing practices, and holistic approaches to health are overlooked or marginalised, impacting the overall well-being of Māori patients, whānau and communities.

### 6.2.3 Unsuccessful Cultural Competency Education

The discussion surrounding perceptions of cultural awareness and competency education within private surgical settings, particularly concerning Māori patient and whānau experiences, reveals a complex landscape of varying opinions, challenges, and critical areas for improvement. Within the findings chapter, there were mixed perceptions of organisational commitment to cultural competency education. Some participant accounts suggested that their hospitals were committed to enhancing Māori patient experiences through cultural awareness initiatives. Others expressed doubts about the authenticity and motivations behind similar initiatives in their hospitals. Some participants viewed these initiatives as mere compliance exercises, lacking genuine engagement and understanding. Further, they stressed the importance of comprehensive historical education for healthcare practitioners regarding Te Ao Māori, mātauranga Māori, colonisation, Te Tiriti o Waitangi, and cultural and political discourse. This knowledge was seen as fundamental in understanding the context and the 'why' behind cultural competency education for Māori health.

While participants recognised the importance of education on Ngā Paerewa Health and Disability Services Standard for compliance and improved patient care, a lack of willingness among staff to engage fully was clear, potentially due to a lack of understanding or appreciation of the importance of cultural competency specific to Māori health outcomes. Some participants expressed the superficial nature of staff engagement, indicating a lack of absorption of crucial information. Several factors contributing to staff reluctance included cultural differences, limited awareness of the Māori worldview, and systemic barriers within their organisations. Cultural discomfort and historical organisational issues had appeared to hinder effective engagement in Māori health education. This lack of knowledge about Māori culture resulted in insensitivity and misunderstanding among staff. One participant highlighted the consequences of cultural incompetence on a Māori patient's surgical journey where the patient's whānau felt unwelcome, struggled to understand medical information, and faced hostility from non-Māori medical staff, impacting their overall experience. The participant's intervention exemplified the necessity for staff advocacy and support in such situations, emphasising the absence of relevant training and staff engagement.

There was a consensus among participants that cultural competency education and awareness needed to be deeply embedded throughout their organisations, starting from the highest leadership levels. Although there was some engagement in mandatory online education modules, participants noted a sense of stagnation and a lack of variety in learning modalities. The text-heavy or pre-recorded lecture format of online courses had not effectively engaged learners nor promoted active learning and retention. Moreover, participants advocated for diverse learning opportunities beyond online modules. They stressed the importance of continuous development and growth, suggesting that the current format may not cater to the varied learning preferences of healthcare professionals. The absence of real-life interactions and hands-on experiences in online courses was seen as a limitation. Participants emphasised that practical skills for culturally sensitive patient care are best developed through continuous exposure and real-world practice. A blended approach, combining online learning with in-person workshops and patient interactions, was proposed as a way to improve absorption and application of cultural competency knowledge among healthcare professionals within their hospital settings.

Cultural education within the participants' organisations prioritised cultural competency rather than cultural safety. Historically, regulatory bodies and educational health institutions have predominantly approached cultural competency from an individualised perspective rather than focusing on systemic and organisational processes (Curtis et al., 2019). This approach emphasises the acquisition of cultural knowledge over reflective self-assessment of power dynamics, privilege, and biases. When cultural competency is individualised, it perpetuates a dynamic of "othering," distinguishing those perceived as different from oneself or the dominant culture (Curtis et al., 2019). This practice leads to alienation, marginalisation, limited opportunities, internalised oppression, and exclusion for those who are perceived as 'other.' To ensure safe and effective healthcare interactions, those in positions of power must actively work to dismantle practices that perpetuate this 'othering.'

Approaches to cultural competency that focus on the 'other' tend to oversimplify understandings of different cultures by relying on cultural stereotypes (Chalmers, 2020). This can result in healthcare providers making incorrect assumptions about individual patients, undermining the quality of care provided. Moreover, it reinforces a racialised, binary discourse that disrupts and destabilises Indigenous identity formations (Ramsden, 1990). By ignoring power dynamics, these narrow approaches perpetuate deficit-based narratives, attributing problems solely to affected individuals or communities without considering the role of healthcare professionals, the healthcare system, and broader socio-economic structures (Ramsden, 1990). Achieving health equity necessitates acknowledging and addressing differential power dynamics in healthcare interactions and within broader health systems and social structures, including decision-making processes and resource allocation (Curtis et al., 2019).

An approach to cultural competency focused solely on acquiring knowledge, skills, and attitudes is problematic as it implies that competency can be achieved through a static process. Cultural competency is an ongoing journey without a definitive endpoint. Approaching it as a 'checklist' might lead practitioners to falsely believe they have mastered it. This shows the importance of framing cultural safety as an ongoing, reflective process rooted in 'critical consciousness' (Curtis et al., 2019). While health professionals still require a degree of cultural knowledge, this should not be confused with efforts to address cultural safety. Simply possessing cultural knowledge without deep self-reflection on power dynamics and implications for systems and practices can be hazardous (Ramsden, 1990). Within this study, perhaps a lack of self-reflection on power dynamics, privilege, and biases of the participants' colleagues is the causation for an inability to engage and retain the content of the education.

By overlooking the systemic and organisational drivers of healthcare inequities, individual-focused cultural competency approaches fall short in effectively addressing health disparities (Ramsden, 1990). Healthcare organisations influence provider bias through the structure of their environment, including workforce training, equity accountability, workplace stressors, and diversity in governance and personnel (Chalmers, 2020). Achieving cultural safety involves targeting both individual health professionals and their organisations to address health equity comprehensively.

The concept of cultural safety tends to pose more significant challenges to health institutions, professionals, and students compared to cultural competency. However, it has become increasingly evident that health practitioners, healthcare organisations, and health systems must all engage in working towards cultural safety and critical consciousness (Curtis et al., 2019). To achieve this, they must be willing to critically analyse established power structures and challenge their own biases, privileges, and power dynamics rather than striving for mere 'competence' in understanding other cultures.

## 6.3 Recommendations

### 6.3.1 Implement a Robust Education Change Initiative

Rooted in Māori heritage, Māori nurses bring a deep understanding of Māori values and customs, fostering a whānau-centred approach in care. By prioritising cultural safety and incorporating tikanga Māori practices, they create an inclusive environment where Māori patients feel respected, building trust and rapport (Curtis et al., 2019). This blend of personal and professional values cultivates a culturally safe space, enhancing patient-nurse relationships and addressing the holistic needs of Māori patients, positively impacting their health outcomes and healthcare experiences. Although the development and implementation of Māori nursing workforce strategies is a key priority, it is recommended that private surgical settings foster a culturally inclusive environment by respecting and integrating Māori cultural values and practices first and foremost. By establishing a robust cultural safety, competence and awareness education initiative for current staff, private organisations can create a welcoming and culturally safe workplace for Māori nurses entering these spaces (Curtis et al., 2019).

Based on the literature review, autoethnography and findings chapters of this thesis, it is evident that the core focus areas within an education change-initiative should be based upon Te Ao Māori, tikanga and Te Tiriti o Waitangi. In order to establish an education change-initiative, it is essential to conduct a thorough learning needs assessment (LNA). This assessment should serve to pinpoint the objectives and expected learning results of the planning phase, gather substantiating evidence to guide curriculum innovation, recognise impediments hindering change, scrutinise the influential role of key stakeholders, and furnish a comprehensive framework for both the creation and assessment of the educational intervention. The implementation of constructive alignment and facilitation methods should be apparent throughout the educational journey, showcasing the crucial role of curriculum-innovation in attaining favourable health outcomes for Māori whilst fostering a culturally safe environment for the Māori nursing workforce.

The initial step in a LNA involves clarifying its purpose to establish the foundation for understanding learning needs and developing an appropriate curriculum (Pilcher, 2016). This purpose-driven approach guides data collection methods and interpretation (DeSilets, 2007). For this specific case, targeting health professionals in private surgical settings, the LNA should focus on exploring their knowledge of Te Ao Māori, tikanga, and Te Tiriti o Waitangi in healthcare. The results will set a baseline for future assessments and inform the development of tailored teaching activities.

A key aspect of the initiative should encourage self-reflective practice using adult learning theory, where nurses can leverage existing knowledge of Māori culture (Marcy, 2001). The VARK framework, addressing diverse learning styles, could be integrated to create a multimodal approach for effective education delivery (Marcy, 2001).

The proposed data collection proposes a formal gap analysis to explore current skill levels, uncover performance gaps, and align with cultural safety standards (Bastable, 2017; Pilcher, 2016). Categorising results post-analysis helps prioritise essential learning needs (Burk, 2008), guiding the planning of educational interventions.

The planning phase requires constructive alignment, emphasising interconnectedness among learning outcomes, assessments, and instructional methods (Biggs, 1996). Involving key stakeholders is vital during this phase to overcome workplace cultural barriers (Malik et al., 2015). Continuous reassessment of stakeholder influence should occur to safeguard project development.

To achieve successful curriculum innovation, a systematic approach following constructive alignment is crucial. This involves conceptualisation, building awareness, and relationships with stakeholders, utilising a blended learning approach. Evaluation metrics should include self-reflection, feedback from Māori patients and whānau, and a reduction in reports of cultural loading (Curtis et al., 2019; Rolleston et al., 2022; Komene et al., 2023).

Evaluating the success of cultural safety education initiatives through metrics demonstrates ongoing commitment to improvement, fostering inclusivity, respect, and improved healthcare delivery for Māori patients (Curtis et al., 2019). Feedback from Māori patients and their whānau should be sought to provide insights into the effectiveness of cultural safety education initiatives, while a reduction in reports of cultural loading may indicate improved cultural competence among healthcare providers (Rolleston et al., 2022; Komene et al., 2023).

Finally, the ultimate goal of any healthcare initiative, including cultural safety education, is to enhance health outcomes. When nurses receive training and education that emphasises cultural safety and awareness, it can positively impact patient outcomes (McBride-Henry et al., 2022). This might include improved patient satisfaction, better adherence to treatment plans, increased trust between patients and healthcare providers, and potentially better health outcomes for Māori patients.

### 6.3.2 Develop a Māori Workforce Development Strategy

The Te Whatu Ora Health Workforce Plan stands as a beacon, illuminating the path toward a more equitable and culturally responsive healthcare system in Aotearoa New Zealand. At its core lies a comprehensive strategy aimed at empowering the Māori health workforce. This plan delineates an array of strategies meticulously crafted to address historical disparities, cultural nuances, recruitment, retention, community engagement, leadership, and continuous evaluation (Te Whatu Ora, 2023). Although this workforce plan is tailored at the public sector, there are several aspects that are applicable to Māori workforce development in private healthcare settings. Establishing Māori mentorship initiatives, employing focused recruitment tactics, and incorporating whakapapa leadership principles can cultivate a healthcare workforce that is culturally attuned, thereby improving Māori patient and whānau experiences in private surgical settings (Wiapo & Clark, 2022). This concept will be discussed later in this chapter.

#### *6.3.2.1 Adopt Māori Mentorship as a 'Business as usual' Framework*

The New Zealand Nurses' Organisation (NZNO, 2013) explain that Māori mentorship plays a pivotal role in nursing, serving as a powerful workforce development strategy that intertwines cultural heritage with professional growth. Within Aotearoa New Zealand's healthcare system, where the Māori population faces health disparities, the guidance and support provided by Māori mentors to aspiring nurses of Māori descent are invaluable. These mentorship programs not only nurture clinical skills but also instil cultural competence, fostering a deeper understanding of Māori values, customs, and holistic approaches to health (NZNO, 2013). By bridging cultural gaps and empowering Māori nurses to embrace their heritage within their profession, mentorship initiatives significantly contribute to a more inclusive, culturally sensitive healthcare workforce, ultimately enhancing health outcomes for the Māori community and strengthening the overall fabric of the nursing profession (Kensington-Miller & Ratima, 2015). Therefore, it is recommended that private healthcare organisations adopt a robust Māori mentorship model.

Mentoring stands as a crucial facet of professional nursing practice and represents one of the most impactful methods for nurturing individuals. The elements defining the mentoring relationship encompass empowerment, mutual respect, shared learning, serving as a role model, providing constructive feedback, extending support, and offering encouragement (Tahau-Hughes, 2010). Despite mentorship primarily aiming to enrich the mentee's personal and professional development, it is designed to be advantageous for both the mentor and mentee.

For Māori, the guiding principles of āwhinatanga, or Māori mentorship, encompass the Māori worldview, strong relationships, shared language, holistic support, respect, shared autonomy, humility, unity, harmony, and perseverance (Hook et al., 2007). Given the diverse cultural makeup of the nursing workforce in New Zealand, it's crucial for any āwhinatanga or mentorship process to acknowledge and respect the cultural norms necessary for a successful outcome (NZNO, 2013).

Maintaining mana, mauri, and wairua are fundamental aspects of an āwhinatanga relationship, recognising the interconnectedness between an individual's progression and that of whānau, hapū, and iwi (Tahau-Hughes, 2010). Tahau-Hughes (2010) has identified key practices in successful mentoring programs for Māori, including prioritising mentoring or āwhinatanga as a crucial support activity, basing programmes on Māori values, principles, and practices with backing from senior management and dedicated resources, utilising data to better cater to Māori needs, fostering long-term, familial-like relationships through mentoring activities, focusing on holistic well-being in these services, contributing to community development and leadership by empowering participants to give back to their communities, and supporting Māori individuals in cultivating their identity.

The nature of the mentoring relationship, whether formal or informal, varies within Aotearoa New Zealand's health organisations, with formal preceptor programs existing alongside the less structured mentorship. Acknowledging the time and workplace support necessary for successful mentorship, all involved parties, including employers, should recognise its importance (NZNO, 2013). Considerations when establishing such relationships involve assessing compatibility between mentor and mentee, aligning with the expectations of whānau, hapū, or iwi, understanding differing communication styles, setting boundaries, addressing disagreements constructively, and providing options for discontinuation if difficulties arise (Tahau-Hughes, 2010). A mentee might select a mentor familiar with their professional growth or find mentorship evolving from an existing supportive connection, whether initiated by the mentor or appointed by a tribal elder (Hook et al., 2007). Collaborating on projects or committees could confirm compatibility, while discussing expectations and boundaries within the relationship remains crucial.

Māori mentorship holds immense significance for the Māori nursing workforce within private hospitals, primarily due to its role in fostering a culturally safe and inclusive healthcare environment. In these settings, where cultural sensitivity and understanding are crucial, Māori mentorship programs provide invaluable support and guidance. They assist Māori nurses in navigating the often complex dynamics of private healthcare while preserving and integrating Māori values, customs, and holistic approaches to care within these settings. These mentorship initiatives not only enhance clinical skills but also promote a deeper appreciation and application of culturally competent care, allowing Māori nurses to effectively address the unique needs of Māori patients and whānau within such settings. As a result, Māori mentorship becomes a cornerstone for creating a culturally responsive nursing workforce, improving patient experiences, and advancing health equity within private healthcare environments. Therefore, it is recommended that private surgical organisations adopt this framework.

#### *6.3.2.2 Implement Targeted Recruitment Strategies*

Targeted recruitment strategies to entice Māori nurses is also vital. Within this research, participants suggested that the recruitment of Māori nurses into private hospitals can be challenging due to various factors. Cultural disconnect, a lack of representation and role models in leadership positions, and the perception of culturally unsafe workplace environments are significant contributors. While there is minimal research exploring appropriate ways to recruit Māori nurses into private healthcare settings, we have the opportunity to leverage from our public sector networks. Waitematā District Health Board (WDHB), now known as Te Whatu Ora – Waitematā, developed and implemented a Māori Workforce Recruitment Toolkit based on the Ministry of Health Pae Ora Framework. Their mission was to attain exceptional health outcomes for the Māori community by valuing every individual, fostering compassion, and emphasising connectivity (WDHB, 2020). They highlighted their dedication to nurturing and expanding the Māori workforce to ensure the best possible care for their community. Further, their purpose was clear whereby they aimed to encompass mauri ora (healthy individuals), whānau ora (healthy families), and wai ora (healthy environments). Based on their own data collection and analyses, their goal was to increase the Māori workforce to ensure it matched that of the Māori population they serve. Their core commitments were to Te Tiriti o Waitangi, partnering with mana whenua (territorial land right holders), improving health equity, upholding Te Ao Māori, and ensuring responsibility and accountability.

Their recruitment process integrated tikanga competencies in position descriptions to emphasise the essential skills required for roles whilst ensuring alignment with Te Tiriti o Waitangi and demonstrate a genuine commitment (WDHB, 2020). To optimise their goals and priorities, they utilised recruitment consultants for Māori specialist roles, ensured shortlisting to prioritise eligible Māori candidates, and carried out interviews involving a structured format focusing on tikanga and culture (WDHB, 2020). Efforts were also made to incorporate Māori representation in interview panels to uphold tino rangatiratanga and kāwanatanga. Whānau support was encouraged during interviews, allowing them to showcase the strengths and attributes of the candidate. Another goal during interviews, was to integrate tikanga and kaupapa Māori within interview practices, fostering a culturally responsive approach. Māori representation on the interview panel was required to facilitate karakia and whakawhanaungatanga. Training resources were available for hiring managers to enhance their understanding and application of kaupapa Māori in interviews (WDHB, 2020).

With regards to offer of employment, candidates were given an opportunity to discuss employment offers with their whānau, emphasising open communication and support. This ensures decisions are informed and consider whānau perspectives. Upon successful appointment, welcoming ceremonies (pōwhiri or whakatau) were carried out to signify respect and acknowledgment whilst upholding kaupapa Māori processes and Te Tiriti o Waitangi.

Based on this evidence, and the content of this thesis, it is recommended that a similar approach be employed within private hospitals. This initiative prioritises cultural competence and sensitivity by incorporating tikanga and kaupapa Māori in the recruitment process. For private hospitals, this signifies a commitment to creating an inclusive environment where Māori nurses feel valued and respected for their cultural identity, thus encouraging a sense of belonging and commitment (Hunter & Cook, 2020). Further, encouraging whānau support during interviews demonstrates an acknowledgment of the importance of family in Māori culture. This practice can help build stronger connections between the hospital and the Māori community, fostering trust and improving community relationships, which can be advantageous for private hospitals seeking to cater effectively to diverse populations. Additionally, the incorporation of kaupapa Māori and tikanga in interviews, along with the provision of resources and training for hiring managers, signifies a commitment to ongoing learning and development. This initiative can attract potential Māori nurses looking for environments that support their professional growth and cultural understanding whilst ensuring a commitment to equity and Te Tiriti o Waitangi. Finally, establishing partnerships or collaborations with local Māori organisations or communities can facilitate access to a larger pool of potential Māori nursing candidates. Such relationships can also lead to mutual learning opportunities and innovative healthcare solutions tailored to Māori needs.

Overall, adopting a recruitment initiative similar to the one outlined could help private hospitals attract, retain, and develop a diverse nursing workforce that reflects and respects the cultural diversity of the communities they serve, leading to better health outcomes and a more inclusive healthcare environment.

#### *6.3.2.3 Champion Māori Leadership Development*

Leadership development holds a pivotal role in the plan for addressing Māori nursing workforce underrepresentation. Tailored leadership programs, networking opportunities, and advocacy for increased representation of Māori voices in decision-making bodies within healthcare organisations and government entities empower Māori health professionals to assume leadership roles and influence policy.

Traditionally, leadership within the healthcare sector has primarily been held by heterosexual, Pākehā (New Zealanders of European descent) males, frequently with medical qualifications, often favouring specific preferences and priorities (Wiapo & Clark, 2022). A pivotal milestone in Māori nursing leadership and on a global scale for Indigenous nursing occurred in 2019. It marked an historic event in Aotearoa New Zealand as, for the very first time, a Māori nurse assumed the position of Chief Nursing Officer in the Ministry of Health (Chalmers, 2020). This appointment held immense significance as it represented a crucial leadership role that wields influence over Māori nursing and healthcare. Thus, creating the opportunity to uphold kāwanatanga. It is recommended that the private sector seek to develop Māori leadership roles within their organisations to ensure there are key change-agents for the improvement of Māori patient and whānau perceptions, experiences and health outcomes.

Māori nursing leadership is indispensable in private hospitals for its role in enhancing cultural responsiveness, reducing health disparities, and fostering trust. The participants within this research project were leaders in their own right, and articulated the need for continuous personal and professional growth to continue to drive positive change for Māori. For Māori nurses to effectively step into leadership roles, an investment into further professional development is recommended. Although all participants expressed gratitude for their employers' commitment to investing in education opportunities, they highlighted that Māori-centric professional development programmes had not been explored or offered. Research suggests that investing in specialised postgraduate programmes designed for Māori nurses focusing on advanced nursing practice, research, and policy represents a crucial step in ensuring equity in their continuous professional development (Chalmers, 2020). It is essential to monitor and publicly disclose the distribution and employment of Māori nurses to ensure alignment with addressing Māori health requirements (Ministry of Health, 2023). Making Māori nurses the primary focus of investment and development within the local nursing workforce should be a priority. We know that leadership is a multifaceted concept applied across various areas in nursing such as policymaking, governance, regulation, education, and clinical practice. Māori leaders in these areas have the ability to tackle intricate institutional and policy obstacles, encompassing issues like institutional bias, disparities, unequal pay, uneven allocation of education funding (for both undergraduates and postgraduates), as well as challenges related to professional growth, and the divided nature of health services and competition, demands active ownership and resolution by nursing leadership (Chalmers, 2020). In essence, these recommendations prioritise Māori nursing leadership investment, addresses disparities in healthcare, advocates for specialised programmes for Māori nurses, monitors workforce distribution, and focuses on nursing workforce development (Te Whatu Ora, 2023).

Discovering suitable forms of leadership might seem unfamiliar and challenging to navigate. When a Māori nurse assumes a leadership position in nursing, they might look up to admired leaders, draw from their own experiences of being led, and explore diverse leadership models as a means of guidance (Hunter, 2019). Unfortunately, most of the nurses within this study expressed a lack of Māori leadership within their organisations. They touched on the need for Māori leadership appointments to bring forth a diverse range of leadership styles that positively impact Māori health outcomes and provide a sense of mentorship for future Māori leaders. Transformational leaders inspire and motivate their followers to achieve extraordinary outcomes (Wiapo & Clark, 2022). Adaptive leadership, on the other hand, is about navigating change and addressing complex challenges (Wiapo & Clark, 2022). Trait theory, however, emphasises identifying specific characteristics or traits inherent in successful leaders (Wiapo & Clark, 2022). While these three leadership theories underpin Māori nursing leadership, deeper levels of Indigenous ideology form the foundation. This is whakapapa leadership. Wiapo and Clark (2022) devised a model likening it to weaving, where whakapapa represents the backbone of the kete (basket), interconnecting diverse elements. The ‘whiri’ forms the kete's structural strength, supporting and uniting its various strands. Whakapapa, intertwining past, present, and future connections, shares the load and nurtures the abilities required for tasks while celebrating the emerging beauty and uniqueness of completeness (Wiapo & Clark, 2022). This process symbolises whakapapa leadership, shaped by the real-life experiences of Māori nurse leaders. Te tāngata symbolises the relational networks Māori nurses utilise to unite people, skills, experiences, and tasks, spiritually uplifting each other and fostering dignity and support. Each strand of this model delves into different aspects: Whakamana te tāngata stresses the spiritual process of mutual upliftment and support; I te wa tika me te waahi focuses on understanding Indigenous history and leveraging change; Te whānau, te hapū, te iwi acknowledges the impact of diverse perspectives on Māori communities; Ngā piki me ngā heke addresses the ups and downs of leadership; Tika, pono (honesty and sincerity) and aroha (love and compassion) highlight complex ethical constructs guiding leaders towards integrity and collective betterment; Mana taurite emphasises equity in collective aspirations (Wiapo & Clark, 2022). Using this framework might highlight the social context shaping leadership, including systems that may hinder it. Despite being perceived negatively, these factors can fortify the kete. Māori nurses' experiences of marginalisation and inequity due to ethnicity, gender, disability, and other factors have reinforced their resilience and adeptness in navigating such systems.

This framework is advocated for implementation in private surgical settings due to its holistic approach. In these settings, it can facilitate a comprehensive and culturally responsive approach to patient care. By integrating whakapapa leadership principles, Māori nurses and healthcare providers can nurture stronger connections with patients. This framework is responsive to equity, ethical conduct, and collective well-being. It allows for a deeper understanding of diverse perspectives and encourages collaboration, thereby enhancing the quality of care and patient outcomes in private surgical settings.

Finally, continuous monitoring and evaluation underpin the entire strategy. Robust data collection, analysis of workforce trends, and outcome measurement serve as compasses guiding the effectiveness of the suggested recommendations in this section. Regular evaluation identifies areas for improvement, enabling dynamic adjustments to further enhance the Māori health workforce strategy's impact.

### 6.3.3 Employ Collaboration and Co-design

Throughout history, private hospitals have traditionally operated independently regarding involvement and cooperation with Māori communities. All data from this study, including the literature review and autoethnography findings, have exposed a significant disconnection between the public and private sectors, private hospitals and iwi/hapū groups, and private entities and Māori healthcare providers. This widening gap illustrates a deficiency in Māori governance, decision-making processes, self-determination, and the incorporation of Indigenous perspectives on 'knowing' and 'being' within private surgical settings. Essentially, the procedures within private healthcare have not adhered to the appropriate tikanga required for engaging Māori in initiatives that impact their health and well-being. Consequently, this perpetuates a continued Westernised approach to Indigenous health, resulting in Māori health initiatives that are unsustainable in nature. Therefore, a key recommendation is for private healthcare organisations to engage in collaborative efforts and co-design methodologies with Māori.

Co-design, increasingly employed in healthcare, involves collaborating with communities to enhance service design and improve health outcomes (Bate & Robert, 2007). This inclusive approach is crucial, particularly in incorporating Indigenous perspectives into health system design, aiming to rectify power imbalances and reduce health disparities. Project teams collaborate with providers, funders, and communities to identify issues, understand experiences, and collectively devise solutions (Boyd et al., 2012). In Indigenous research, co-design entails fair collaboration between researchers and communities, utilising culturally centred participatory methods that recognise communities and participants as experts in their own experiences while researchers facilitate (Rolleston et al., 2022). In Indigenous communities, co-design fosters culturally tailored solutions, aiding implementation, translation, and sustainability.

Although co-design is widely used, it is sometimes misrepresented as mere consultation, where preconceived notions drive design, soliciting community feedback only on specific components (Rolleston et al., 2022). This approach risks reinforcing colonial values and may yield ineffective tools or services that do not align with community expectations. Authentic co-design is time-consuming, logistically complex, and faces challenges due to funding constraints and conflicting philosophies, posing difficulties for researchers and community members to manage (Rolleston et al., 2022).

Embracing kaupapa Māori and mātauranga Māori in health system design is crucial for delivering high-quality services that align with Māori health goals and confront existing disparities. Mahitahi, a kaupapa Māori design approach, embodies core Māori principles of collaboration, collective responsibility, mutual accountability, and communal care (McDonald et al., 2021). Functioning as an effective and culturally attuned framework, mahitahi fosters problem-solving, innovative practices, and creative solutions (Rolleston et al., 2022).

At its core, mahitahi rests upon distinctive mindsets and values that encourage innovative problem-solving approaches. Wānanga, traditional forums for cultural knowledge exchange, are often preferred settings for mahitahi initiatives due to their inherent practices that drive decision-making and knowledge creation (McDonald et al., 2021). Moreover, wānanga promotes an equitable learning process rooted in shared visions and collaborative knowledge development. Collaboration within wānanga is facilitated through practices such as whanaungatanga and manaakitanga (Rolleston et al., 2022).

Co-design and mahitahi processes may seem less structured as they evolve organically throughout project or service design, contrasting with traditional research methodologies where processes are predefined before commencement (McDonald et al., 2021). These approaches adapt and develop naturally as initiatives progress, incorporating a more dynamic and flexible methodology. As a recommendation, the adoption of co-design and mahitahi principles holds significant advantages for private healthcare organisations seeking to enhance their services. Incorporating these methodologies enables a deeper alignment with diverse cultural needs, especially within contexts where patient/whānau-centred care is paramount. By actively engaging in co-design and mahitahi, private healthcare entities can foster stronger relationships with the communities they serve, facilitating a more nuanced understanding of their health aspirations and needs.

### 6.3.4 Magnify and Apply Critical Tiriti Analysis (CTA)

In addition to the application of co-design and mahitahi, the CTA framework is a useful adjunct. As mentioned in Chapter One, the CTA framework centres on a nuanced exploration of key components within Te Tiriti o Waitangi, diverging from the use of partnership, participation, and protection as primary principles in evaluating Māori health and well-being. CTA emphasises critical examination of Te Tiriti’s text, highlighting each of the elements as the preamble, kāwanatanga, tino rangatiratanga, ōritetanga, and wairuatanga (Came et al., 2020). These elements form the crux of the framework, enabling a comprehensive assessment of healthcare practices, policies, and systems. By prioritising Māori self-determination, equity, the Crown's responsibilities, and holistic health perspectives, CTA guides efforts to address historical injustices, disparities, and inequities in healthcare while centring Māori voices, autonomy, and well-being. A CTA can be carried out retrospectively or prospectively.

Retrospective CTA involves a meticulous examination of historical healthcare practices and policies concerning Māori communities in light of the key components of Te Tiriti. This analysis scrutinises how past decisions, actions, and policies have affected Māori health outcomes (Came et al., 2020), dissecting how each of the articles have been upheld or compromised in healthcare delivery over time. Retrospective CTA requires a comprehensive exploration of historical healthcare policies and practices to uncover instances where Te Tiriti was upheld, respected or breached (Came et al., 2020). For instance, it examines whether Māori were actively engaged in decision-making processes regarding healthcare, whether services were culturally responsive and equitable, and whether authorities supported or hindered Māori self-determination and holistic health practices. By scrutinising past policies and practices, it sheds light on systemic biases, discrimination, and disparities that have contributed to poorer health outcomes among Māori communities (Came et al., 2020). This analysis provides insights into the long-term repercussions of historical injustices on current health disparities. By acknowledging historical wrongdoings and the impact on Māori health, healthcare providers and policymakers can take proactive steps towards redressing these inequities (McBride-Henry et al., 2022). This involves implementing policies that align with Te Tiriti o Waitangi, engaging Māori communities in decision-making, and developing culturally safe healthcare services.

Similarly, a prospective CTA provides an avenue for meticulous planning of policies, initiatives and processes. Unlike the retrospective CTA process, Māori considerations are explored during the early stages of process development and continue to be present across the continuum towards implementation. Taking an approach guided by the articles of Te Tiriti, The inception of a prospective CTA involves firstly grounding healthcare stakeholders in the recognition of the preamble, emphasising how policies respect existing Māori authority, foster relationships, and contribute to peace and order (Came et al., 2023). In relation to Article One, considerations revolve around honourable kāwanatanga, ensuring Māori involvement in policy/initiative benefits determination. Further, alignment with kāwanatanga involves preserving Māori interests and meaningful inclusion (Came et al., 2023). Progressing into visionary planning, the underpinnings of tino rangatiratanga (Article Two) guide envisioning healthcare policies and initiatives that honour Māori self-determination (Berghan et al., 2017). Stakeholders contemplate these to enable Māori substantive engagement in setting priorities and approaches. This phase strives for Māori leadership in policy development, ensuring their satisfaction and substantial involvement (Came et al., 2023). The design phase centres on ōritetanga (Article Three) stressing equitable healthcare design benefiting Māori. Policies and initiatives emphasise meaningful Māori involvement in decision-making, resource allocation, and eliminating disparities (Came et al., 2020). Finally, the pivotal phase of wairuatanga (Article Four, the oral article) entails supporting Māori to live by their values and customs, integrating spirituality and psychological well-being into policies and initiatives. It emphasises the influence of wairuatanga on initiative outcomes and aligning processes with Māori values (Came et al., 2023). In essence, this approach to the development of policies, initiatives and processes can be viewed as mana-enhancing and it is highly recommended to enact this framework within private surgical settings.

In conclusion, integrating co-design, mahitahi, and CTA into the development of various healthcare-related aspects for Māori patients and whānau who enter private surgical settings is imperative for fostering culturally responsive, equitable, and effective healthcare systems. These frameworks empower Māori communities, healthcare providers, educators, and policymakers to work collaboratively, acknowledge historical context, and address systemic challenges, ultimately leading to improved health outcomes and a more inclusive healthcare environment for Māori in Aotearoa New Zealand.

### 6.4 Strengths of the Research

Within this study, kaupapa Māori methodology embodied a distinctive framework deeply entrenched in Māori culture, prioritising Māori knowledge, values, and aspirations. One of its prominent strengths lay in its emphasis on a small number of participants, which was evident in this project, facilitating a thorough, profound and comprehensive analysis. This methodology's cultural grounding fostered the development of cultural identity by centring on Māori cultural elements, which contributed significantly to understanding diverse perspectives. Moreover, kaupapa Māori methodology placed a strong emphasis on empowerment and participation. By actively involving Māori individuals in the research process, it cultivated empowerment and self-determination. Its holistic approach, aligning with the interconnectedness inherent in the Māori worldview, enabled a comprehensive understanding of issues by considering their multifaceted nature. Cultural respect served as a cornerstone of this methodology, valuing Māori knowledge systems, language, and customs. This practice promoted profound respect for Indigenous ways of ‘knowing’, ‘being’ and ‘doing’.

Autoethnography, a valuable method for deep reflexivity, enabled me to delve into personal experiences and perspectives authentically. This approach enhanced the understanding of cultural nuances and context by embracing subjectivity and authenticity. It empowered a 'marginalised voice', providing a platform for my narrative to challenge dominant discourses. Additionally, reflexivity within autoethnography and the application of the Gibbs' Reflective Cycle encouraged deep self-reflection, heightened my awareness of my positionality within the research process, and aided in the development of personal-professional intersectionality.

Reflexive thematic analysis, known for its flexibility and adaptability, complemented these frameworks by enabling qualitative data analysis. Its application through a kaupapa Māori lens offered ease and fluidity within various aspects of the research process. By emphasising systematic analysis and coding, it fortified rigour and transparency in the research project. This facilitated the identification of patterns, themes, and underlying meanings within the data, thereby providing profound insights.

The strengths of kaupapa Māori methodology, autoethnography, and reflexive thematic analysis collectively contribute to enriched and culturally sensitive research practices. These not only facilitate comprehensive analysis but also empower marginalised voices, foster cultural understanding, and promote rigorous and transparent research processes. Their combined utilisation offers a potent framework for conducting research that respects diverse perspectives and enhances the depth of scholarly inquiry.

## 6.5 Limitations of the Research

Kaupapa Māori methodology, autoethnography, and reflexive thematic analysis have garnered recognition for their distinct advantages. However, these approaches are not without their challenges and critiques, impacting their implementation and outcomes within research contexts.

With regards to the use of kaupapa Māori methodology, hurdles were anticipated when being applied outside its cultural context. This was evident within the reflexive thematic analysis process as it was unfamiliar to me. Critics highlight the potential for cultural bias, asserting that the inherent cultural orientation may skew research findings, limiting their applicability in broader settings. However, this kaupapa Māori methodology study was designed by Māori, for Māori. Therefore, was the most appropriate framework for this research where the underpinning values were applied to this construct.

Similarly, the use of autoethnography was challenging. Its emphasis on personal experiences inherently limits the generalisability and objectivity of findings, although the effects of emotional resonance can positively impact on the transferability and efficacy of the findings (Ellis, Adams & Bochner, 2011). Further, critics question the validity and rigour of autoethnography due to its heavy reliance on subjective experiences. The subjective nature of this process opens it to criticism, particularly regarding its credibility in producing robust and reliable research outcomes. Ethical considerations also surfaced, especially when discussing sensitive or personal topics. However, I employed mitigation plans to navigate the ethical complexities of the research.

Reflexive thematic analysis, despite its merits, presents challenges of potential reductionism and researcher subjectivity. The process of identifying themes in data may have oversimplified complex information, potentially losing rich contextual details. However, applying a kaupapa Māori lens mitigated this reductionism by preserving cultural nuances and depth within the analysis. Researchers' subjectivity further complicates reflexive thematic analysis, as biases may influence the interpretation of themes, affecting the objectivity of the analysis. However, it was intended to envelop my own subjective experiences within the process which strengthened the reflexive aspect of thematic analysis. Additionally, the time-consuming nature of analysing qualitative data through thematic analysis was a significant challenge. Extensive coding and interpretation demanded substantial time and effort. However, this process allowed for a deep familiarisation with the dataset.

While kaupapa Māori methodology, autoethnography, and reflexive thematic analysis offer valuable insights and approaches in research, they are not immune to criticism and challenges. Issues such as cultural specificity, subjectivity, ethical dilemmas, validity concerns, reductionism, and time intensiveness underscore the complexity and limitations of these methodologies. Despite these challenges, addressing these concerns through meticulous planning, reflexivity, and contextual understanding has enhanced the robustness and applicability of this research conducted using these methodologies.

## 6.6 Implications

The participants within this study each expressed narratives of enhancing Māori patient and whānau experiences through the natural embeddedness of Te Ao Māori and cultural advocacy. This underscores the transformative impact of integrating Māori values into healthcare, particularly within nursing roles. This integration significantly influences the clinical setting, enhancing Māori patient outcomes by fostering a culturally safe environment rooted in whānau-centred care and cultural appropriateness. Nurses' incorporation of tikanga Māori practices prioritises cultural safety, creating inclusive spaces where Māori patients feel respected and understood, positively affecting their health experiences.

A key aspect highlighted is the intersection of personal and professional values among Māori nurses, drawing from the concepts of manaakitanga, whānau, and whanaungatanga. These values, deeply embedded in the Māori creation story, underpin nursing practices, highlighting interconnectedness, balance, and the importance of relationships. However, this integration of cultural values also exposes challenges, notably the burden of excessive cultural expectations placed on Māori nurses, leading to burnout and inequitable workloads.

Moreover, the study uncovers systemic gaps in private healthcare settings regarding Māori engagement, cultural competence, and representation in decision-making roles. It exposes the urgent need for policy reforms that prioritise genuine collaboration, cultural safety, and shared decision-making in healthcare. Addressing these gaps involves advocating for organisational change, comprehensive cultural education, and ongoing professional development to instil deeper cultural understanding, critical consciousness, and systemic change among healthcare practitioners.

Overall, this research calls for a paradigm shift within healthcare, advocating for a move from individual-focused cultural competency to a systemic approach centred on cultural safety, equitable collaboration, and dismantling power imbalances. The broader implications encompass healthcare policy reforms, organisational changes, and enhanced professional development to create inclusive, culturally safe healthcare environments that better serve the diverse needs of Māori communities, ultimately aiming to address disparities and promote equitable health outcomes.

## 6.7 Conclusion

In conclusion, this research underscores the transformative potential of integrating Māori values into healthcare practices within private settings. The emphasis on cultural safety, rooted in whānau-centred care and Māori values, significantly influences patient outcomes and experiences. However, it also reveals critical challenges, such as the burden of cultural expectations on Māori nurses and systemic gaps in private healthcare engagement with Māori communities.

This chapter advocates for holistic solutions, urging private healthcare organisations to prioritise cultural safety education, genuine collaboration, and policy reforms that empower Māori voices and ensure equitable representation. Implementing Māori mentorship programs, targeted recruitment strategies, and whakapapa leadership principles can foster a culturally responsive healthcare workforce and enhance patient experiences within private surgical settings. Furthermore, integrating co-design, mahitahi, and the CTA framework into healthcare initiatives is crucial for promoting culturally responsive, equitable, and effective healthcare systems for Māori patients and whānau.

Despite the strengths of kaupapa Māori methodology, autoethnography, and reflexive thematic analysis, there are limitations, including cultural specificity, subjectivity, and ethical dilemmas, which need careful consideration when applying these to research.

Ultimately, this study emphasises the imperative for private healthcare organisations to honour Māori values, engage in genuine collaboration, and prioritise cultural safety and Te Tiriti o Waitangi.

# 7 Chapter Seven: Final Notes – Echoes of Exploration

This thesis provides an in-depth exploration of multiple interconnected themes, unveiling critical aspects of Māori nursing experiences in healthcare within private surgical services. The initial segment emphasises the historical and contemporary repercussions of colonisation, socio-economic disparities, and the influence of Western ideologies on Māori health. It articulates how racism, discrimination, and institutional practices stemming from colonisation hinder cultural health literacy and relationships between Māori patients/whānau and healthcare professionals. Despite these challenges, it sheds light on the positive aspects of understanding historical complexities for informed future progress, thereby highlighting the necessity for ongoing research. Subsequent chapters delve into an autoethnographic exploration, intertwining personal and professional encounters across cultural identity. This narrative navigates through the Gibbs' reflective cycle, illuminating recurrent themes of cultural competence, racism, and organisational structures linked to colonisation and Western ideologies. However, it culminates in a perspective that envisions hope and potential change, empowering the researcher to advocate for the Māori population and fostering a robust sense of identity.

Further chapters discuss the symbiotic relationship between critical theory, kaupapa Māori methodology, and the research process, advocating for acknowledging the past and utilising Indigenous research for transformative changes. The integration of kaupapa Māori principles, whakapapa, and whakawhanaungatanga exemplifies the interconnectedness vital to this research, emphasising the sovereignty of lived experiences in shaping narratives.

The methodological chapter underscores the centrality of kaupapa Māori principles in data collection, analysis, and interpretation. It elucidates how purposive sampling, aligned with critical theory and kaupapa Māori, facilitated in-depth exploration despite the limited number of participants. The employment of videotelephony interviews, reflexive thematic analysis, and reflexive entries further fortified the depth and authenticity of the research.

The final chapters address the research question: How can the current experiences and perceptions of Māori nurses expose and reshape future realities for Māori patients and whānau when engaging in private surgical services? These chapters summarise the emergent themes from participant interviews, advocating for the acknowledgment of Māori nurses' invaluable attributes, the necessity for collaborative approaches transcending sectors, and the urgency of cultural education initiatives within private healthcare settings. These findings showcase the imperative need for change in private surgical services and have implications extending beyond this research to inform transformative actions.

The culmination of these chapters meticulously examines Māori nursing experiences in private healthcare settings, showcasing the transformative potential of integrating Māori values. It advocates for cultural safety, genuine collaboration, and policy reforms within private healthcare, emphasising equity, representation, and cultural responsiveness. However, it recognises the methodological limitations and underscores the ongoing need for private healthcare entities to honour Māori values and prioritise cultural safety, thereby exposing and reshaping future realities for Māori patients and whānau within private surgical services.

Throughout my engagement in this research project, I've been fortunate to experience significant personal and professional growth that has evolved alongside the project's progress. Each lesson learned during this research journey has found its way into my current practice, resulting in several notable accomplishments.

I've had the privilege of being entrusted with a national Māori advisory role within the nursing directorate of a private surgical health organisation, marking a pivotal moment as the first-ever Māori leadership role within my organisation. I have had the opportunity to apply co-design and mahitahi methodologies to shape policy development and cultural education initiatives. Collaborative efforts led to the creation and implementation of Māori roles – Kaimahi (Māori cultural support) and Kaiārahi (Māori Ambassador) – and the development of a comprehensive Hauora Māori Committee charter.

Additionally, the integration of Critical Tiriti Analysis and tikanga into the organisational fabric aims to foster inclusivity. Establishing connections among Māori members within the organisation aims to create a sense of unity and shared purpose. The endeavour to co-design a National Hauora Māori strategy to address broader health concerns was a collective effort.

Engaging with iwi and mana whenua has been a humbling experience, allowing for meaningful relationships and dialogue. Additionally, I played a role in spearheading the development of a Māori health navigator framework and initiating a national Māori governance group, both endeavours aligning closely with the principles of my kaupapa Māori research process.

These pursuits have been deeply aligned with the ethos of my research. The journey has been both challenging and enlightening, shaping my personal and professional identity. This alignment has enriched my journey, nurturing a growing sense of mana and humility along the way.

I end this thesis with a poem, to summarise the rich tapestry of this mana-enhancing journey...

*In the shadows of surgical halls, I dive,*
*Exploring Māori tales, woven deep in time,*
*Chapters unfurl, revealing interconnected threads,*
*Māori health in private care, where stories shed.*

*The first chapter sings of history's weight,*
*Colonial echoes, a burdening freight.*
*Socio-economic divides, a tale too grim,*
*Western notions dimming culture's hymn.*

*Racism's whispers echo, discrimination's might,*
*Colonial shackles tight, obscuring the light.*
*These hurdles, stark, obstructing the way,*
*Yet wisdom sprouts, learning from yesterday.*

*Through autoethnographic eyes, I see,*
*A fusion of personal and professional glee.*
*Gibbs' cycle guides, through reflection's course,*
*Unveiling cultural competence, a potent force.*

*Caught in the web of critical theory's grace,*
*Kaupapa Māori, a compass to embrace.*
*Narratives entwine, past and present collide,*
*A yearning for change, with identity's pride.*

*In symbiotic dance, theories converge,*
*Kaupapa embrace, stories to purge.*
*Whakapapa essence, connections deep,*
*Shaping narratives, truths to keep.*

*Methodology speaks, in Māori tongue,*
*Purposive sampling, though few, souls among.*
*Videotelephony whispers stories, unseen,*
*Thematic reflections, analysis keen.*

*Emerging themes bloom from interviews' core,*
*Māori nurses' essence, an untapped store.*
*Collaboration's plea, crossing sector's span,*
*Cultural education, a vital plan.*

*These chapters, a mosaic, stories arise,*
*Demanding change, a fervent prize.*
*In private health's realm, a call to see,*
*Equity's mantle, cultural safety.*

*But limitations loom, as shadows might,*
*Ongoing need, honour in sight.*
*Private care's journey, Māori plea,*
*For safety, equity, for futures free.*

*In closing, these chapters, a heartfelt plea,*
*Māori's essence in healthcare, let us see.*
*Transformative whispers, policy's reform,*
*Reshaping destinies, breaking norms.*
*(Cowles, 2024).*

# References

Abbasinia, M., Ahmadi, F., & Kazemnejad, A. (2020). Patient advocacy in nursing: A concept analysis. *Nursing Ethics, 27*(1), 141-151. https://doi.org/10.1177/0969733019832950

Anderson, L. (2006). Analytic autoethnography. *Journal of Contemporary Ethnography, 35*(4), 373-395. https://journals.sagepub.com/doi/epdf/10.1177/0891241605280449

Armendariz-Dyer, M. J. (2020). “Thou Shalt Not Die in This Place”: An ethnomethodological approach to an Ecuadorian hospice through symbolic interactionism. *Omega: Journal of Death & Dying, 82*(2), 278–293. https://doi-org.ezproxy.aut.ac.nz/10.1177/0030222818810042

Bastable, S. B. (2017). *Nurse as educator: Principles of teaching and learning for nursing practice*. (5th ed.). Jones & Bartlett Learning, LLC. http://ebookcentral.proquest.com/lib/aut/detail.action?docID=5144466

Bate, P., & Robert, G. (2023). *Bringing user experience to healthcare improvement: the concepts, methods and practices of experience-based design*. CRC Press.

Berghan, G., Came, H., Coupe, N., Doole, C., Fay, J., McCreanor, T., & Simpson, T. (2017). Te Tiriti o Waitangi-based practice in health promotion. STIR: Stop Institutional Racism. https://trc.org.nz/sites/trc.org.nz/files/ToW%20practice%20in%20HP%20online.pdf

Boud, D. (2001). Using journal writing to enhance reflective practice. *New Directions for Adult and Continuing Education* (90), 9-17. https://ezproxy.aut.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&site=eds-live&db=eric&AN=EJ630506

Boyd, H., McKernon, S., Mullin, B., & Old, A. (2012). Improving healthcare through the use of co-design. *The New Zealand Medical Journal, 125*(1357), 76–87. https://pubmed.ncbi.nlm.nih.gov/22854362/

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* SAGE.

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201-216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., Clarke, V., Hayfield, N., Terry, G. (2019). Thematic Analysis. In P. Liamputtong (ed.), *Handbook of research methods in health social sciences* (pp. 843-860). Springer. https://doi-org.ezproxy.aut.ac.nz/10.1007/978-981-10-5251-4_103

Came, H., Baker, M., & McCreanor, T. (2021). Addressing structural racism through constitutional transformation and decolonization: Insights for the New Zealand health sector. *Journal of Bioethical Inquiry, 18*(1), 59-70-70. https://doi.org/10.1007/s11673-020-10077-w

Came, H., Kidd, J., & Goza, T. (2020a). A critical Tiriti analysis of the New Zealand Cancer Control Strategy. *Journal of Cancer Policy, 23*. https://doi.org/10.1016/j.jcpo.2019.100210

Came, H., Kidd, J., O'Sullivan, D., & McCreanor, T. (2023). Critical Tiriti Analysis: A prospective policy making tool from Aotearoa New Zealand. *Ethnicities, 0*(0), 1-20. https://doi.org/10.1177/14687968231171651

Came, H., O'Sullivan, D., & McCreanor, T. (2020b). Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy. *Ethnicities, 20*(3), 434-456. https://doi.org/10.1177/1468796819896466

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Bywaters, D., Young, S., & Walker, K. (2020). Purposive sampling: complex or simple? Research case examples. *Journal of Research in Nursing, 25*(8), 652-661. https://doi.org/10.1177/1744987120927206

Chalmers, L. (2020). Responding to the State of the World's Nursing 2020 report in Aotearoa New Zealand: Aligning the nursing workforce to universal health coverage and health equity. *Nursing Praxis in Aotearoa New Zealand, 36*(2), 7-19. https://doi.org/10.36951/27034542.2020.007

Cooper, R., & Lilyea, B. V. (2022). I'm Interested in autoethnography, but how do I do it? *The Qualitative Report, 27*(1), 197-208. https://doi.org/10.46743/2160-3715/2022.5288

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health, 18*(1), 1-17. https://doi.org/10.1186/s12939-019-1082-3

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health, 7*(2). https://doi.org/10.1136/fmch-2018-000057

Denieffe, S. (2020). Commentary: Purposive sampling: complex or simple? Research case examples. *Journal of Research in Nursing, 25*(8), 662-663. https://doi.org/10.1177/1744987120928156

Denzin, N. (2015). What is critical qualitative inquiry? In G. S. Canella, M. S. Perez, & P. A. Pasque (Eds.), *Critical qualitative inquiry: Foundations and futures* (pp. 31-49). Taylor & Francis Group. http://ebookcentral.proquest.com/lib/AUT/detail.action?docID=1996929

Dodgson, J. E. (2019). Reflexivity in Qualitative Research. *Journal of Human Lactation: Official Journal of International Lactation Consultant Association, 35*(2), 220-222. https://doi.org/10.1177/0890334419830990

Duncan, S., & Rewi, P. (2018). Tikanga: How not to get told off. In Carter, L., Duncan, S., Leoni, G., Paterson, L., Ratima, M. T., Reilly, M., & Rewi, P (Eds), *Te Koparapara: An Introduction to the Māori World*. (pp. 37-50). Auckland University Press. http://ebookcentral.proquest.com/lib/aut/detail.action?docID=5704672

Durie, M. (2011). *Ngā tini whetū: navigating Māori futures.* Huia. http://ebookcentral.proquest.com/lib/AUT/detail.action?docID=1359688

Ellis, C., Adams, T. E., & Bochner, A. P. (2011). Autoethnography: An overview. *Historical Social Research / Historische Sozialforschung, 36*(4 (138)), 273-290.

https://ezproxy.aut.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&site=eds-live&db=edsjsr&AN=edsjsr.23032294

Freund, K. M. (2017). Implementation of evidence-based patient navigation programs. *Acta Oncologica, 56*(2), 123-127. https://doi.org/10.1080/0284186X.2016.1266078

Galletta, A. (2013). *Mastering the semi-structured interview and beyond: From research design to analysis and publication.* New York University Press.

Graham, R., & Masters-Awatere, B. (2020). Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research. *Australian & New Zealand Journal of Public Health, 44*(3), 193-200. https://doi.org/10.1111/1753-6405.12971

Grant, M. J., & Booth, A. (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Information & Libraries Journal, 26*(2), 91-108. https://doi.org/https://doi.org/10.1111/j.1471-1842.2009.00848.x

Gross, J. J. (2023). *Handbook of Emotion Regulation* (3rd ed.). Guilford Publications. https://ebookcentral.proquest.com/lib/AUT/detail.action?docID=30772785

Haitana, T., Pitama, S., Cormack, D., Clarke, M., & Lacey, C. (2020). The transformative potential of Kaupapa Māori research and indigenous methodologies: Positioning Māori patient experiences of mental health services. *International Journal of Qualitative Methods, 19*. https://doi.org/10.1177/1609406920953752

Hardcastle, M. A., Usher, K., & Holmes, C. (2006). Carspecken's five-stage critical qualitative research method: An application to nursing research. *Qualitative Health Research, 16*(1), 151-161. https://doi.org/10.1177/1049732305283998

Heck, L. O., Carrara, B. S., Mendes, I. A. C., & Arena Ventura, C. A. (2022). Nursing and advocacy in health: An integrative review. *Nursing Ethics, 29*(4), 1014-1034. https://doi.org/10.1177/09697330211062981

Hiha, A. A. (2015). Kaupapa Māori methodology: Trusting the methodology through thick and thin. *The Australian Journal of Indigenous Education, 45*(2), 129-138. https://doi.org/10.1017/jie.2015.30

Hilder, J., Gray, B., & Stubbe, M. (2019). Health navigation and interpreting services for patients with limited English proficiency: a narrative literature review. *Journal of Primary Health Care, 11*(3), 217-226. https://doi.org/10.1071/HC18067

Holodynski, M., & Friedlmeier, W. (2006). *Development of emotions and emotion regulation*. Springer. https://ezproxy.aut.ac.nz/login?url=https://link.springer.com/10.1007/b101090

Hook, G. E. R., Waaka, T., & Raumati, L. P. (2007). Mentoring Māori within a Pākehā framework. *MAI Review, 3*(1), 1-13. https://natlib-primo.hosted.exlibrisgroup.com/primo-explore/fulldisplay?vid=NLNZ&docid=INNZ7114207270002837&context=L&search_scope=INNZ

Horsfall, J., Cleary, M., & Hunt, G. E. (2012). Developing a pedagogy for nursing teaching-learning. *Nurse Education Today, 32*(8), 930-933. https://www-sciencedirect-com.ezproxy.aut.ac.nz/science/article/pii/S026069171100284X?via%3Dihub

Hunter, K. (2019). The significant cultural value of our Māori nursing workforce. *Nursing Praxis in New Zealand, 35*(3), 4-6. https://doi.org/10.36951/NgPxNZ.2019.009

Hunter, K., & Cook, C. (2020). Indigenous nurses' practice realities of cultural safety and socioethical nursing. *Nursing Ethics, 27*(6), 1472-1483. https://doi.org/10.1177/0969733020940376

Huria, T., Cuddy, J., Lacey, C., & Pitama, S. (2014). Working with racism: A qualitative study of the perspectives of Māori (indigenous peoples of Aotearoa New Zealand) Registered Nurses on a global phenomenon. *Journal of Transcultural Nursing, 25*(4), 364-372. https://doi.org/10.1177/1043659614523991

Ide, Y., & Beddoe, L. (2022). Attitude or skills? Cultural competence development within an Aotearoa New Zealand bicultural framework. *Aotearoa New Zealand Social Work Review, 34*(4), 47-60. https://doi.org/10.11157/anzswj-vol34iss4id954

Ingham-Broomfield, B. (2021). A nurses' guide to using models of reflection. *Australian Journal of Advanced Nursing, 38*(4), 62-67. https://doi.org/10.37464/2020.384.395

Jacobson, D., & Mustafa, N. (2019). Social identity map: A reflexivity tool for practicing explicit positionality in critical qualitative research. *International Journal of Qualitative Methods, 18*, 1-12. https://doi.org/10.1177/1609406919870075

Jones, C. P. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health, 90*(8), 1212-1215. https://doi.org/10.2105/AJPH.90.8.1212

Keegan, T.T. (2000). Tikanga Māori, Reo Māori ki te Ipurangi: Māori Culture & Language on the Internet. https://www.cs.waikato.ac.nz/~tetaka/PDF/TikangaMāori .pdf

Kennedy, V., Cram, F., Paipa, K., Pipi, K., & Baker, M. (2015). Wairua and cultural values in evaluation. *Evaluation Matters – He Take Tō Te Aromatawai, 1*, 83-111. https://www.researchgate.net/profile/Fiona-Cram/publication/282509793_Wairua_and_cultural_values_in_evaluation/links/5865936c08ae8fce490c26c3/Wairua-and-cultural-values-in-evaluation.pdf

Kensington-Miller, B., & Ratima, M. (2015). Māori in partnership: a peer mentoring model for tertiary indigenous staff in New Zealand. *Race, Ethnicity & Education, 18*(6), 813-833. https://doi.org/10.1080/13613324.2013.831824

Kidd, J., Black, S., Peni, T., & Blundell, R. (2018). Cultural health literacy: the experiences of Māori in palliative care. *Global Health Promotion, 25*(4), 15-23. https://doi.org/10.1177/1757975918764111

Kivunja, C., & Kuyini, A. B. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education, 6*(5), 26-41. https://ezproxy.aut.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&site=eds-live&db=eric&AN=EJ1154775

Komene, E., Gerrard, D., Parr, J., Pene, B., Aspinall, C., & Wilson, D. (2023). A tohu (sign) to open our eyes to the realities of Indigenous Māori registered nurses: A qualitative study. *Journal of Advanced Nursing, 79*(7), 2585-2596. https://doi.org/10.1111/jan.15609

Kraaijeveld, M. I., Schilderman, J. B. A. M., & van Leeuwen, E. (2021). Moral sensitivity revisited. *Nursing Ethics, 28*(2), 179-189. https://doi.org/10.1177/0969733020930407

Kvale, S. (2007). Doing Interviews. In. SAGE Publications, Ltd. https://doi.org/10.4135/9781849208963

Le Roux, C. S. (2017). Exploring rigour in autoethnographic research. *International Journal of Social Research Methodology, 20*(2), 195-207. https://doi.org/10.1080/13645579.2016.1140965

Madden, A., Bailey, C., Alfes, K., & Fletcher, L. (2018). Using narrative evidence synthesis in HRM research: An overview of the method, its application, and the lessons learned. *Human Resource Management, 57*(2), 641-657. https://doi.org/10.1002/hrm.21858

McBride-Henry, K., Roguski, M., Miller, C., Van Wissen, K., & Saravanakumar, P. (2022). Re-orientating health and nursing care: a qualitative study on indigenous conceptualisations of wellbeing. *BMC Nursing, 21*(1), 1-12. https://doi.org/10.1186/s12912-022-01063-1

McDonald, M., Waitoki, W., & Rolleston, A. (2021). Whakapiki Wairua: Co-designing and implementing a Māori mindfulness mental health intervention in a Wharekura. *MAI Journal, 10*(3), 71-83. https://researchcommons.waikato.ac.nz/handle/10289/14743

McGrath, C., Palmgren, P. J., & Liljedahl, M. (2019). Twelve tips for conducting qualitative research interviews. *Medical Teacher, 41*(9), 1002-1006. https://doi.org/10.1080/0142159X.2018.1497149

McLachlan, A., Pitama, S., & Adamson, S. J. Kia whakatomuri te haere whakamua: Engaging Maori rural communities in health and social service care. *AlterNative: An International Journal of Indigenous Peoples, 16*(3), 202-210. https://ezproxy.aut.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&site=eds-live&db=edsnzc&AN=edsnzc.446427377001666

Ministry of Health. (2019). *WAI 2575 Māori Health Trends Report: 1990-2015.* https://www.health.govt.nz/publication/wai-2575-maori-health-trends-report

Ministry of Health. (2022). *Health and Independence Report 2021: The Director-General of Health's Annual Report on the State of Public Health.* https://www.health.govt.nz/publication/health-and-independence-report-2021

Ministry of Health. (2023). *Pae Tū: Hauora Māori Strategy*. https://www.health.govt.nz/publication/pae-tu-hauora-maori-strategy

Moyle, P. (2014). A model for Māori research for Māori practitioners. *Aotearoa New Zealand Social Work Review, 26*(1), 29-38. https://ezproxy.aut.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&site=eds-live&db=sih&AN=97205701

New Zealand Nurses Organisation. (2013). *Mentorship/Āwhinatanga*. https://www.nzno.org.nz/LinkClick.aspx?fileticket=BxYYxkAHhzE%3D&portalid=0

NHS Institute for Innovation and Improvement. (2010). *The handbook of quality and service improvement tools*. https://www.google.com/search?client=firefox-b-d&q=The+Handbook+of+Quality+and+Service+Improvement+Tools%2C+NHS

NZS 8134:2021 Ngā Paerewa Health and Disability Services Standard 2021 (N. Z.). https://www.standards.govt.nz/shop/nzs-81342021/

O'Carroll, A. D. (2013). Kanohi ki te kanohi, a thing of the past? Examining the notion of virtual ahikā and the implications for kanohi ki te kanohi. Pimatisiwin: *A Journal of Aboriginal and Indigenous Community Health, 11*(3), 441–455. https://journalindigenouswellbeing.co.nz/wp-content/uploads/2014/02/09OCarroll.pdf

Oliver, M. (1998). Theories in health care and research: Theories of disability in health practice and research. *BMJ: British Medical Journal, 317*(7170), 1446-1449. https://www-ncbi-nlm-nih-gov.ezproxy.aut.ac.nz/pmc/articles/PMC1114301/

Paterson, C., & Chapman, J. (2013). Enhancing skills of critical reflection to evidence learning in professional practice. *Physical Therapy in Sport, 14*(3), 133-138. https://ezproxy.aut.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&site=eds-live&db=s3h&AN=89299180

Pelzang, R., & Hutchinson, A. M. (2018). Establishing cultural integrity in qualitative research: Reflections from a cross-cultural study. *International Journal of Qualitative Methods, 17*(1). https://doi.org/10.1177/1609406917749702

Pene, B-J., Aspinall, C., Wilson, D., Parr, J., & Slark, J. (2021). Indigenous Māori experiences of fundamental care delivery in an acute inpatient setting: A qualitative analysis of feedback survey data. *Journal of Clinical Nursing, 31,* 3200-3212. https://doi.org/10.1111/jocn.16158

Pōtiki, M. (2018). Takiauē (Tangihanga): Death and mourning. In Carter, L., Duncan, S., Leoni, G., Paterson, L., Ratima, M. T., Reilly, M., & Rewi, P (Eds), *Te Koparapara: An Introduction to the Māori World.* (pp. 131-142). Auckland University Press. http://ebookcentral.proquest.com/lib/aut/detail.action?docID=5704672

Powell, J. L. (2013). *Symbolic Interactionism.* Nova Science Publishers Incorporated. https://ebookcentral.proquest.com/lib/AUT/detail.action?docID=2194033#

Ramsden, I. (1990). *Kawa Whakaruruhau: Cultural safety in nursing education in Aotearoa.* Wellington: Ministry of Education.

Reilly, M. (2018). Te Tīmatanga mai o te ao: The beginning of the world. In Carter, L., Duncan, S., Leoni, G., Paterson, L., Ratima, M. T., Reilly, M., & Rewi, P (Eds), *Te Koparapara: An Introduction to the Māori World*. (pp. 18-36). Auckland University Press. https://ebookcentral.proquest.com/lib/aut/reader.action?docID=5704672&ppg=37

Richardson, S., Williams, T., Finlay, A., & Farrell, M. (2009). Senior nurses' perceptions of cultural safety in an acute clinical practice area. *Nursing Praxis in New Zealand, 25*(3), 27-36. https://ezproxy.aut.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&site=eds-live&db=ccm&AN=105270846

Ritchie, J. (2015). Counter-colonial research methodologies drawing upon postcolonial critique and indigenous onto-epistemologies. In G. S. Canella, M. S. Perez, & P. A. Pasque (Eds.), *Critical qualitative inquiry: Foundations and futures* (pp. 77-90). Taylor & Francis Group. http://ebookcentral.proquest.com/lib/AUT/detail.action?docID=1996929

Rolleston, A. K., Cassim, S., Kidd, J., Lawrenson, R., Keenan, R., & Hokowhitu, B. (2020). Seeing the unseen: Evidence of Kaupapa Māori health interventions. *AlterNative: An International*

*Journal of Indigenous Peoples, 16*(2), 129-136. https://doi.org/10.3316/informit.234700924594739

Rolleston, A. K., Korohina, E., & McDonald, M. (2022). Navigating the space between co-design and mahitahi: Building bridges between knowledge systems on behalf of communities. *Australian Journal of Rural Health, 30*(6), 830-835. https://doi.org/10.1111/ajr.12916

Rolleston, A., McDonald, M., & Miskelly, P. (2022). Our story: a Māori perspective of flourishing whānau. *Kotuitui: New Zealand Journal of Social Sciences, 17*(3), 277-297. https://doi.org/10.1080/1177083X.2021.1981955

Rossman, G. B., & Rallis, S. F. (2017). *An introduction to qualitative research: Learning in the field.* SAGE Publications Incorporated. https://dx.doi.org/10.4135/9781071802694

Selket, K., Glover, M., & Palmer, S. (2015). Normalising post-mortems – whose cultural imperative? An indigenous view on New Zealand post-mortem policy. *Kotuitui: New Zealand Journal of Social Sciences, 10*(1), 1-9. https://doi.org/10.1080/1177083X.2014.901233

Seneviratne, S., Campbell, I., Scott, N., Coles, C., & Ross Lawrenson, R. (2015). Treatment delay for Māori women with breast cancer in New Zealand. *Ethnicity & Health, 20*(2), 178–193, http://dx.doi.org/10.1080/13557858.2014.895976

Smith, L. T. (2015). Kaupapa Māori research- Some Kaupapa Māori principles. In L. Pihama & K. South (Eds.), *Kaupapa Rangahau A Reader: A Collection of Readings from the Kaupapa Maori Research Workshop Series Led* (pp. 46-52). Te Kotahi Research Institute. https://hdl.handle.net/10289/12026

Stevenson, K. (2018). A consultation journey: developing a Kaupapa Māori research methodology to explore Māori whānau experiences of harm and loss around birth. *AlterNative, 14*(1), 54-62-62. https://doi.org/10.1177/1177180117744612

Tabakakis, C., McAllister, M., & Bradshaw, J. (2022). Exploring resilience and workplace adversity in registered nurses: A qualitative analysis. *Nursing and Health Sciences, 24*(1), 174-182. https://doi.org/10.1111/nhs.12912

Tahau-Hodges, P. (2010). *Kaiako Pono: Mentoring for Māori learners in the tertiary sector*. Ako Aotearoa. https://ako.ac.nz/assets/Knowledge-centre/NPF-07-01-kaiako-pono/RESEARCH-REPORT-Kaiako-Pono-Mentoring-for-Maori-Learners-in-the-Tertiary-Sector.pdf

Te Whatu Ora. (2023). *Health workforce plan 2023/24*. https://www.tewhatuora.govt.nz/publications/health-workforce-plan-202324/

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic Analysis. In C. Willig & W. Stainton-Rogers (Eds.), The SAGE Handbook of Qualitative Research in Psychology (2nd ed, pp. 17-37). https://ebookcentral.proquest.com/lib/aut/reader.action?docID=4882015&ppg=50

The Pūtaiora Writing Group. (2019). Te Ara Tika Guidelines for Māori research ethics: A framework for researchers and ethics committee members. Health Research Council of New Zealand.

Theunissen, K. E. (2011). The nurse's role in improving health disparities experienced by the indigenous Māori of New Zealand. *Contemporary Nurse, 39*(2), 281-286. https://doi.org/10.5172/conu.2011.281

Thomas, C., Weller, J., Rahiri, J. L., Harwood, M., & Pitama, S. (2022). Māori experiences of hospital care: a qualitative systematic review. *AlterNative, 18*(3), 455-464. https://doi.org/10.1177/11771801221114385

Traynor, M. (2017). *Critical resilience for nurses: an evidence-based guide to survival and change in the modern NHS.* Routledge. http://ebookcentral.proquest.com/lib/AUT/detail.action?docID=4831624

Tyson, L. (2015). *Critical theory today: a user-friendly guide* (3rd Ed). Taylor & Francis Group. http://ebookcentral.proquest.com/lib/AUT/detail.action?docID=1813148

Waitematā District Health Board. (2020). *Māori Workforce Recruitment Toolkit: A toolkit for the integration of Taha Māori into the Waitematā DHB recruitment process.* https://managersguide.wdhbcareers.co.nz/assets/WDHB_-Maori-Workforce-Recruitment-Doc_2020.pdf

Waitangi Tribunal. (2019). *HAUORA: Report on stage one of the health services and outcomes kaupapa inquiry-WAI 2575*. https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

Warren, TR., Forster, M., & Tawhai, V. (2021). Tangata Whenua: Māori, identity and belonging. In Cain, T., Kahu, E., & Shaw, R. (Eds.), *Turangawaewae: Identity and belonging in Aotearoa New Zealand* (pp. 45-59). Massey University Press. https://ebookcentral.proquest.com/lib/aut/reader.action?docID=6665978&ppg=246

Wiapo, C., & Clark, T. C. (2022). Weaving together the many strands of Indigenous nursing leadership: Towards a whakapapa model of nursing leadership. *Nursing Praxis in Aotearoa New Zealand, 38*(2), 4-11. https://doi.org/10.36951/27034542.2022.08

Wiisak, J., Suhonen, R., & Leino-Kilpi, H. (2022). Whistle-blowers – morally courageous actors in health care? *Nursing Ethics, 29*(6), 1415-1429. https://doi.org/10.1177/09697330221092341

Wilson, D., & Baker, M. (2012). Bridging two worlds: Māori mental health nursing. *Qualitative Health Research, 22*(8), 1073-1082. https://doi.org/10.1177/1049732312450213

Wilson, D., Heaslip, V., & Jackson, D. (2018). Improving equity and cultural responsiveness with marginalised communities: Understanding competing worldviews. *Journal of Clinical Nursing, 27*(19-20), 3810-3819. https://doi.org/10.1111/jocn.14546

Wilson, D., Mikahere-Hall, A., & Sherwood, J. (2022). Using indigenous Kaupapa Māori research methodology with constructivist grounded theory: generating a theoretical explanation of indigenous womens realities. International Journal of Social Research Methodology, 25(3), 375-390. https://doi.org/10.1080/13645579.2021.1897756

Wilson, D., Moloney, E., Aspinall, C., Slark, J., & Parr, J. M. (2021). Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of Clinical Nursing, 30*(23-24), 3539-3555-3555. https://doi.org/10.1111/jocn.15859

Wylie, L., & McConkey, S. (2019). Insiders' insight: Discrimination against Indigenous peoples through the eyes of health care professionals. *Journal of Racial and Ethnic Health Disparities, 6*(1), 37-45. https://doi.org/10.1007/s40615-018-0495-9

Yalçın, B., Baykal, U., & Turkmen, E. (2021). Why do nurses choose to stay silent?: A qualitative study. *International Journal of Nursing Practice, 23*(1), e13010. https://doi.org/10.1111/ijn.13010

# Appendices

## Appendix A: Glossary

Aroha – Love and compassion

Aroha ki te tangata – Expression of love to other people

Hapū – Sub-tribe

Hauora – Holistic health

He kai kei aku ringa – There is food at the end of my hands

He waka eke noa – A canoe in which we are all in, with no exceptions

Hinengaro – Emotional and mental wellbeing/the mind

Hōhā – Nuisance

Hui – Large gathering

I te wa tika me te waahi – Indigenous history and leveraging change

Iwi – Tribe

Kaiārahi – Māori Ambassador

Kaimahi – Māori cultural support

Kaitiakitanga – Process of achieving guardianship

Kanohi ki te kanohi – Face to face

Karakia – Prayer

Kaumātua – Elder

Kaupapa Māori – Māori approach

Kāwantanga – Governance

Kete – Basket

Koha – Reciprocity/gift

Kōrero – Conversation

Koro – Grandfather

Kupu – Word

Mā te wā – All in good time

Mahi – Work

Mahitahi – Kaupapa Māori initiative approach

Mamae – Hurt

Mana – Strength and identity

Mana taurite – Equity in collective aspirations

Mana whenua – Territorial land right holders

Manaaki ki te tangata – Respecting narratives

Manaakitanga – Nurturing relationships/hospitality/respect

Marae – Meeting place

Mātauranga Māori – Traditional Māori knowledge

Mauri – Life force

Mauri ora – Healthy individuals

Mirimiri – Massage

Ngā piki me ngā heke – Ups and downs of leadership

Noho puku – Respecting autonomy and reflection

Ōritetanga – Citizenship/Equity

Pākehā – New Zealanders of European descent

Pono – Honesty and sincerity

Pōwhiri – Formal welcoming ceremony

Rangatira – Chief

Rongoā – Traditional healing practices

Tangata whenua – Connection to the land

Tangi – Funeral

Tangihanga – Cultural expression during death

Taonga – Sacred/worthy of protection

Taonga tuku iho – Cultural continuance

Tapu – Sacred or prohibited

Tautoko – Support

Te Ao Māori – The Māori worldview

Te Ao Pākeha – The Western worldview

Te reo Māori – Māori language

Te Tiriti o Waitangi – Māori text of the Treaty of Waitangi

Te Whare Tapa Whā – Māori model of Health and well-being

Te Whatu Ora – Public sector health entity

Tika – Truth and justice

Tikanga – Māori system of customs and traditions

Tinana – Physical body

Tino rangatiratanga – Sovereignty

Titiro – Look

Tuku wairua – Prayer to release the spirit from the body

Tūpuna – Ancestors

Wai ora – Healthy environments

Waiata – Song

Wairua/Wairuatanga – Spiritual strength and practice

Wānanga – Forum for cultural knowledge exchange

Whaiwhia te kete mātauranga – Fill the basket with knowledge

Whakamana te tāngata – Spiritual process of mutual upliftment and support

Whakapapa – Genealogy or lineage

Whakarongo – Listen

Whakatau – Welcoming ceremony

Whakataukī – Māori proverb

Whakawhanaungatanga – Process of building connections

Whānau – Family and extended family

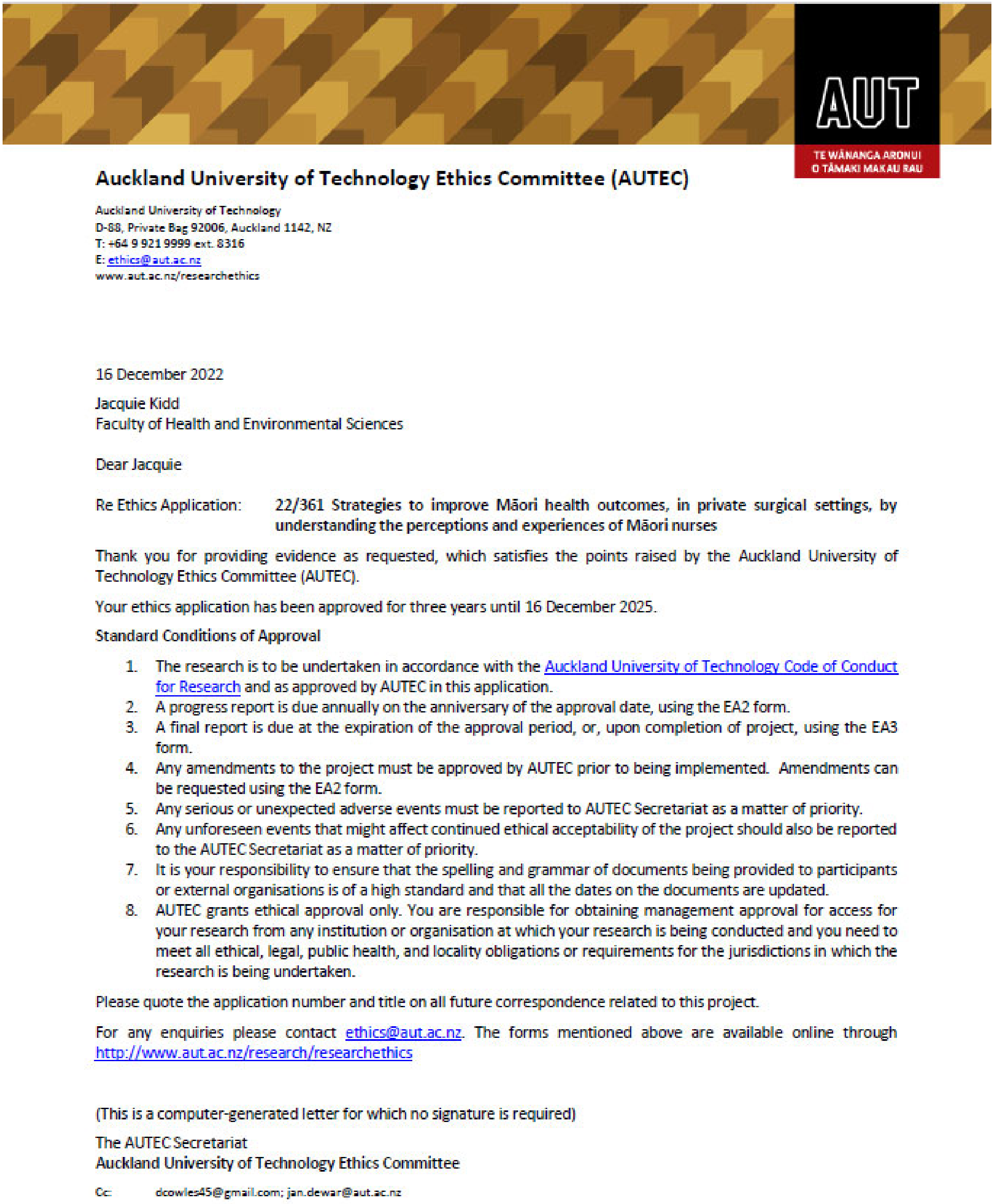
Whānau ora – Healthy families

Whanaungatanga – Binding of relationships

Whenua – Land

Whiri – Braiding together

# Appendix B: Ethics Approval Letter



**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

16 December 2022

Jacquie Kidd
Faculty of Health and Environmental Sciences

Dear Jacquie

Re Ethics Application: **22/361 Strategies to improve Māori health outcomes, in private surgical settings, by understanding the perceptions and experiences of Māori nurses**

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 16 December 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.

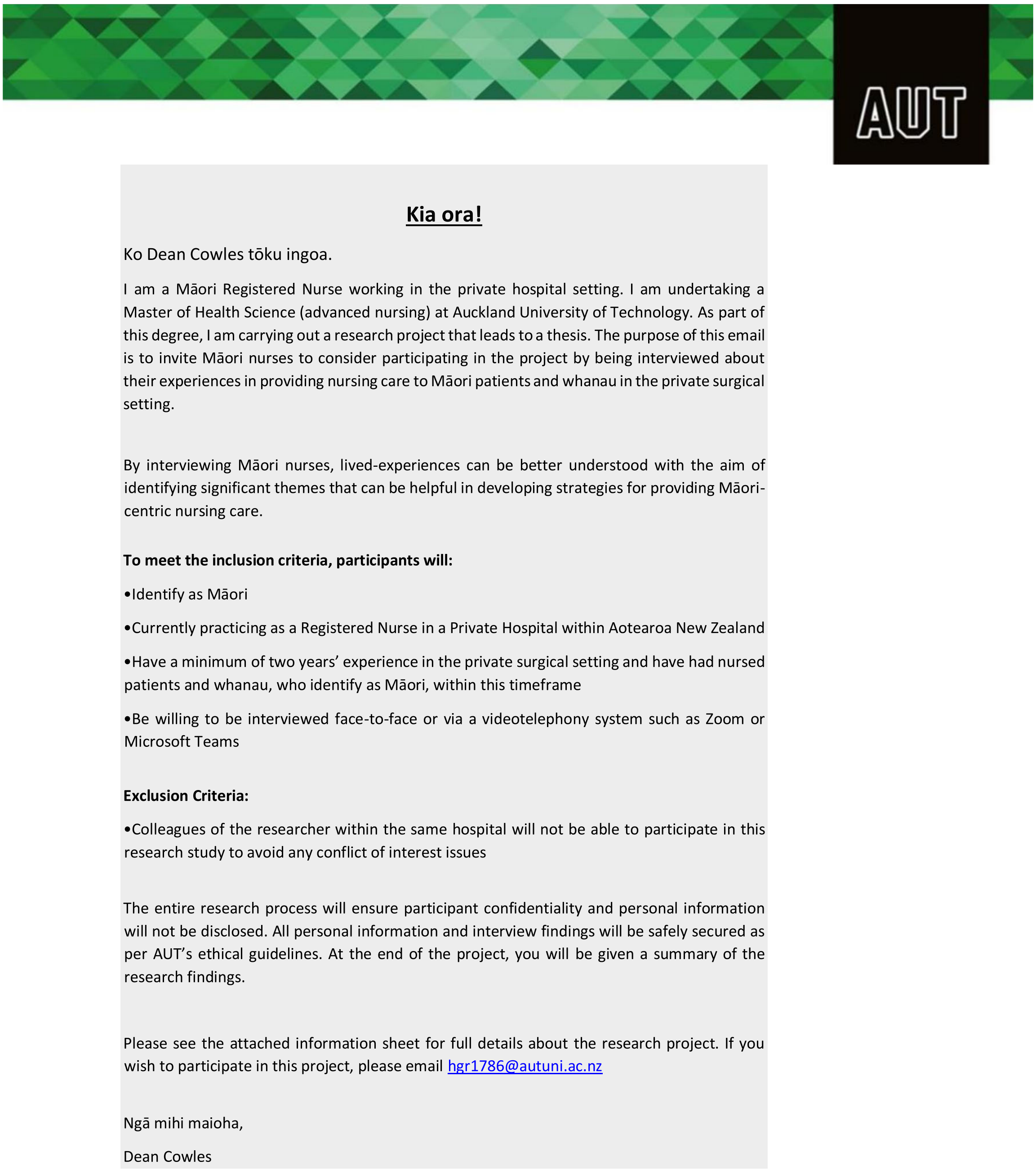
For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

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

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: dcowles45@gmail.com; jan.dewar@aut.ac.nz

## Appendix C: Advertisement



**Kia ora!**

Ko Dean Cowles tōku ingoa.

I am a Māori Registered Nurse working in the private hospital setting. I am undertaking a Master of Health Science (advanced nursing) at Auckland University of Technology. As part of this degree, I am carrying out a research project that leads to a thesis. The purpose of this email is to invite Māori nurses to consider participating in the project by being interviewed about their experiences in providing nursing care to Māori patients and whanau in the private surgical setting.

By interviewing Māori nurses, lived-experiences can be better understood with the aim of identifying significant themes that can be helpful in developing strategies for providing Māori-centric nursing care.

**To meet the inclusion criteria, participants will:**

- Identify as Māori
- Currently practicing as a Registered Nurse in a Private Hospital within Aotearoa New Zealand
- Have a minimum of two years' experience in the private surgical setting and have had nursed patients and whanau, who identify as Māori, within this timeframe
- Be willing to be interviewed face-to-face or via a videotelephony system such as Zoom or Microsoft Teams

**Exclusion Criteria:**

- Colleagues of the researcher within the same hospital will not be able to participate in this research study to avoid any conflict of interest issues

The entire research process will ensure participant confidentiality and personal information will not be disclosed. All personal information and interview findings will be safely secured as per AUT's ethical guidelines. At the end of the project, you will be given a summary of the research findings.

Please see the attached information sheet for full details about the research project. If you wish to participate in this project, please email hgr1786@autuni.ac.nz

Ngā mihi maioha,

Dean Cowles

## Appendix D: Participant Information Sheet

# Participant Information Sheet

**Date: 16th December 2022**

**Project Title**

Strategies to improve Māori health outcomes, in private surgical settings, by understanding the perceptions and experiences of Māori nurses.

**An Invitation**

Tēnā koe!

Ko Dean Cowles tōku ingoa. I am undertaking a Master of Health Science (advanced nursing) at Auckland University of Technology. As part of this degree, I am carrying out a research project that leads to a thesis. This purpose of this information sheet is to invite you to participate in the project by being interviewed about your experiences in providing nursing care to Māori patients and whanau in the private surgical setting. If you agree to being interviewed for this project, all measures will be taken to keep your personal information confidential and you will not be identified throughout the research process.

**What is the purpose of this research?**

This Kaupapa Māori study aims to explore nurses’ perceptions and experiences of the implications that Māori patients and whanau face, when engaging in private surgical services, whereby Te Tiriti o Waitangi application has not been upheld. The research will provide recommendations for the practical application of Te Tiriti o Waitangi to enhance the experience, perception and recovery for the Māori population, across the surgical continuum, within private surgical settings.

By interviewing you, I will be able to understand your lived-experiences with the aim of identifying significant themes that can be helpful in developing strategies for providing Māori-centric nursing care.

The findings of this research may be used for academic publications and presentations.

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

This study is aimed to recruit participants across Aotearoa New Zealand. As we have approximately 73 privately-owned surgical hospitals and clinics across the country, dissemination of the advertisement and information sheet was sent to the New Zealand

Private Surgical Hospital's Association. The email advertisement, along with the information sheet, was then sent to the Executive Director of this association to disseminate to all Leadership members. Once each individual hospital leader had reviewed and understand the value of this research study, they shared these with their Māori nursing workforce. Also, the Director of Digital Indigenous went through a similar process and disseminated the documents within her network of Nga Manukura o Apopo graduates.

To meet the inclusion criteria, participants will:

- Identify as Māori
- Currently practicing as a Registered Nurse in a Private Hospital within Aotearoa New Zealand
- Have a minimum of two years' experience in the private surgical setting and have had nursed patients and whanau, who identify as Māori, within this timeframe
- Be willing to be interviewed face-to-face or via a videotelephony system such as Zoom or Microsoft Teams

Exclusion Criteria:

- Colleagues of the researcher within the same hospital will not be able to participate in this research study to avoid any conflict of interest issues

**How do I agree to participate in this research?**

As you have responded to an advertisement, you have taken the next step to explore the possibility of participating in a research project.

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.

If you choose to participate in this research, and meet the inclusion criteria, you will be asked to complete a consent form. This will be provided to you via email or in person (depending on if your interview takes place online or face-to-face). Participants will be provided with a $50 supermarket voucher as a koha.

4-6 participants will be recruited on a 'first in first served' basis.

**What will happen in this research?**

This research will maintain your confidentiality. This means that the researcher named below will be aware of your identity, but the research data will be combined, and your identity will not be revealed in any reports, presentations or public documents. However, please be aware that this a small project and your identity might be obvious to others within your community. This will be mitigated by recruiting participants from different organisations.

If you are successfully recruited into this study, your interview time, date and setting will be organised to suit you and your availability. To ensure tikanga practices are upheld, karakia (prayer) will be performed. To build trust, rapport, and create a safe space, whakawhanaungatanga (establishing connections) will be carried out before explaining the purpose of the research, the interview structure, and your rights.

Your interview will be either verbally recorded (face-to-face interviews) or videorecorded (online interviews) and will be transcribed afterwards by the primary researcher. Only my research supervisors and I will read the transcripts. All interview recordings, transcriptions and summaries will be securely stored and destroyed after the project is complete.

Below is a breakdown of how much of your time that may be required for this

project

60 minutes for interviews

30 minutes for communication of project details and arranging interviews

15 minutes for post-interview follow up (if requested by participant)

30 minutes for communicating research analysis data back to the

participants

**What are the discomforts and risks?**

This research will give you the opportunity to voice your lived experiences relating to barriers that you have faced when striving to provide Māori-centred nursing care. Although this is a great avenue to share experiences, some people may find this confronting and can experience unexpected emotions. Rest assured, these feelings are natural, and we can pause or cease the interview at your request.

Potential participants may feel unwilling and anxious about sharing their own experiences within the hospital that they work in. They may fear repercussions from their employers. However, you will not be asked to disclose the name of your hospital or employer. Further, the names of the hospitals and their locations will not be included in the data or report-outputs. Participants will also be provided a pseudonym during transcription. Each transcription will be coded, so your confidentiality will be upheld. The study is about the broad private sector approach to Māori health, rather than what individual organisations are doing.

Any data that might identify a specific organisation will be removed from the transcripts and not included in the analysis or findings.

### How will these discomforts and risks be alleviated?

To mitigate any discomfort, it will be emphasised that this project strives to be 'mana-enhancing' with the overarching values of Kaupapa Māori. The interview questions, setting and communication modalities will strive to optimise tikanga, matauranga Māori, and Te Tiriti o Waitangi.

If you require additional support, below is an outline of Puāwaitanga services that are available to you:

Puāwaitanga means to blossom, to flourish, to break through, and is a phone and web-based service to support Kiwis to improve their emotional wellbeing – their hauora. The service is an alternative to face to face counselling for Kiwis who are struggling but face challenges in accessing traditional counselling. All staff are trained professionals and counselling sessions are private, confidential and free. Many of the counsellors embed Te Ao Māori, Tikanga and Māori health models within their practice.

**Firstly, go to the Puāwaitanga website:**

- You complete an enrolment questionnaire, choose your counsellor and book an initial appointment, all via the Puāwaitanga patient portal.
- In your first appointment you will talk with the counsellor about what you would like to achieve, come up with plan on how to achieve these and discuss how many sessions you may need to attend do this.
- Over the course of the programme the counsellor and you work together to identify strategies to achieve your goals and increase your wellbeing.

You can find out more information about Puāwaitanga on their website:

https://puawaitanga.nz/ or call 0800 782 999

**What are the benefits?**

The information from my research will be used in my Master's thesis and may be used in future presentations or academic publications.

This study aims to examine the historical complexities associated with Māori-centric nursing care whilst enabling future possibilities to re-indigenise healthcare. In addition to improving clinical practice, this project will strive to enhance perceptions, experiences and recovery for Māori patients and whanau within the private surgical setting. With your input in this research study, your experiences, perceptions and stories that you have shared with me have real potential for change-innovation. Here, you would have played an instrumental part in advocating for our Māori communities. You would have done your part in improving Māori health outcomes in the private surgical setting.

**How will my privacy be protected?**

The research will maintain the privacy and confidentiality of your personal details and data from your interview. Any details of your organisation will also be kept private and confidential and will not be identified in the research.

Privacy and confidentiality processes will adhere to the AUT ethics guidelines and AUT Code of Conduct for research. Also, pseudonyms will be used for all participants early in the process (during interview transcription) to minimise any risk of revealing their identities.

Data minimisation and use-limitation will be maintained by limiting the amount of personal information that is collected and retained. Your information that will be collected will only be relevant and necessary to the needs of the project. Details of employers will not be retained.

We will be open and honest about what information is collected and how it will be used. Within the informed consent process, a clear explanation will be given to you about the type of data that will be collected, the purpose, how the information will be used, data security and storage, and you rights. This will be in this information sheet, consent form, and verbal explanation.

The security of your details will be maintained by giving all electronic and paper information to the Primary Researcher who will keep these stored on the AUT password-secured electronic/computer database. This data will only be accessible by the researcher and primary supervisor.

**What opportunity do I have to consider this invitation?**

Once you have been identified as a potential participant, you will be given one month to consider the invitation to take part in this study.

**Will I receive feedback on the results of this research?**

Once your interview has been transcribed, you will be given the opportunity to review the written account of your interview responses to make sure they are accurate and correct.

After analysing the data, you will be provided a one or two page summary of the findings.

**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, *Jacquie Kidd, Jacquie.Kidd@aut.ac.nz*

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. You are also able to contact the research team as follows:

**RESEARCHER CONTACT DETAILS:**

Dean Cowles

hgr1786@autuni.ac.nz

**PROJECT SUPERVISOR CONTACT DETAILS:**

Jacquie Kidd

Jacquie.Kidd@aut.ac.nz

022 3585 022

***Approved by the Auckland University of Technology Ethics Committee on 16th December 2022***

***AUTEC Reference number 22/361*** *Note: The Participant should retain a copy of this form.*

# Appendix E: Oral Consent Protocol

## Oral Consent Protocol

For use when interviews are being conducted by videoconference.

*Project title:* ***Strategies to improve Māori health outcomes, in private surgical settings, by understanding the perceptions and experiences of Māori nurses.***

*Project Supervisor:* ***Jacquie Kidd***

*Researcher:* ***Dean Cowles***

*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 **16th December 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.?

○ I Understand the information that will be collected will only be relevant and necessary to the needs of the project

○ I understand the type of data that will be collected, the purpose, how the information will be used, data security and storage, and my rights

○ 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? Yes ○ No ○

○ Do you want me to send you a copy of the audio recording for this consent? Yes ○ No ○

○ Please confirm your name and contact details

Date……………………………………………………………………………..

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 16th December 2022***

***AUTEC Reference number 22/361*** *Note: The Participant should retain a copy of this form.*

## Appendix F: Semi-structured Interview Questions

1) As a Māori nurse, can you explain some values that are important to you and your practice?
*Probing Questions: Where do these values come from? How have they shaped you as a person? How have they shaped you as a nurse? What does it mean to be a Māori nurse?*

2) What are your thoughts about the quality of Māori health supports available to Māori patients and whānau in the organisation you work for?
*Probing Questions: How are these accessed? How are these made known to patients, whānau and staff? What else is needed to ensure there are robust support systems in place for Māori patients and whānau? In your opinion, how does your organisation prioritise or not prioritise Māori health?*

3) How have you provided Māori-centred nursing care to Māori patients and whānau?
*Probing Questions: What frameworks did you use? What practices did you employ? How do these relate to your values?*

4) What strategies has your organisation developed to educate health professionals about Te Tiriti o Waitangi, tikanga, Te Ao Māori and/or mātauranga Māori?
*Probing Questions: How do you think these have improved cultural health literacy? Have these strategies been successful and why/why not?*

5) Think about a time that you incorporated Tiriti o Waitangi, tikanga, Te Ao Māori and/or mātauranga Māori within your practice. How did you do this and how did it impact on patients, whānau and/or your colleagues?
*Probing Questions: How did you incorporate kāwanatanga, ōritetanga, tino rangatiratanga and wairuatanga into your practice? How were you able to facilitate karakia, whanaungatanga and tikanga into the provision of care? How receptive were your colleagues to this? What is your view on the importance of applying these practices when nursing Māori patients & whānau?*

6) Can you explain any barriers or issues that you have faced when providing Māori-centred care for Māori patients and whānau?
*Probing Questions: What were your thoughts and feelings about this? In your opinion, how do you think these barriers and issues can be tackled? Who do you think should be accountable for developing strategies to overcome these and why? Can you explain how you should be supported in providing Māori-centred care?*

7) How does your organisation support your professional development as a Māori nurse?
*Probing Questions: If not, what opportunities would you like in order to grow as a Māori nurse? If so, how has this aided in your development and what else is needed to help achieve your professional goals? Professionally, where do you see yourself in five years?*

8) What is your understanding about the current guidelines or policies that directly affect Māori, within your organisation and/or the wider health system, and how do they help improve Māori health outcomes?
*Probing Questions: How can these be improved? If they are not helping improve Māori health outcomes, why do you think this is? What are your thoughts about utilising Māori consultation in the development of these guidelines and policies? To your knowledge, can you think of an example when you have seen a guideline or policy positively influence Māori patients and whānau at your hospital?*

9) How do YOU think your organisation can enhance the experience, perception and recovery for Māori patients who have surgery in private hospitals?
*Probing Questions: What would you like to see enacted in your organisation in order to positively change Māori health outcomes?*