Enhancing Connections:
International Medical Graduates Cultural Orientation Programmes in Rural Māori Communities

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Abstract

International Medical Graduates (IMGs) supply a significant proportion of the General Practitioners (GPs) in rural Aotearoa New Zealand. In Te Tai Tokerau Northland, these communities often consist of large Māori communities that have their own specific cultural realities that shape how we experience hauora (health). This thesis explores the experiences and worldviews of these two groups and how cultural orientation programmes shape medical interactions. I employ reflexive journalling along with semi-structured interviews, to document current IMG orientation practices from the perspective of IMGs and local Iwi leadership in the Hokianga. Participants are developed from Te Tai Tokerau with a focus on Hauora Hokianga, the local Māori health provider. A total of 7 participants were formally interviewed, consisting of 5 IMGs and 2 representatives of local Iwi. Key findings from this research indicate that IMGs need more time and educational support to integrate successfully into rural Māori communities. There is a desire within these locations to reconnect with traditional ways-of-being that encourage interconnectivity and promote health through decolonization. Developing cultural awareness education programmes through the guidance of local Iwi, helps to communicate the socio-cultural contexts that shape how the community experience hauora. The broader significance of my work is to further understand how the worldviews of two disparate groups can be bridged to improve health outcomes for rural Māori.

Acknowledgements

Ka mua, Ka muri

We walk backwards into the future.

My research has led me on a journey through my own past towards a more harmonious sense of cultural identity. The journeys through Te Tai Tokerau Northland led me back to the home of my mother and followed a retracing of the steps of my tūpuna back to the Hokianga. In some ways, this journey mirrors the desire of many Māori to reconnect with their pasts. Having an opportunity to not only learn more about a topic that I am invested in, but to grow personally from the experience as well, is something that I am grateful for.

My desire to understand more about IMG orientation stemmed from a concern about how health interactions between Māori and Tauiwi (non-Māori) doctors were being mediated through cultural awareness programmes. I had an insight into how culturally appropriate education was occurring through my wife, who is an IMG, and how well these programmes were being received by kaimahi (staff). This experience intersected with my experience of Māori dissatisfaction with health services, and feelings of cultural alienation in some medical consultations. To give myself the best opportunity of understanding the dynamics of these interactions, I needed to grasp the nuances of orientation, from both an IMG and local Iwi perspective. Through my whanau connections, I was lucky enough to have guidance about who and where to locate these unique viewpoints.

Hauora Hokianga is in many ways the perfect location for research on IMG orientations in rural Aotearoa New Zealand. Being a community health trust has allowed the organisation to tailor their approach to Hauora Māori (Māori health) and staff cultural education. They are currently pursuing initiatives that are aimed at improving the links between Iwi and the organisation in ways that should improve health experiences for local Māori. They also boast a workforce of health workers whose dedication epitomises the capabilities of community empowerment. I would like to thank the hospital staff first and foremost for the warmth and graciousness of their

welcome. Time pressure within these organisations is a constant theme of this research, so I am grateful for the opportunity to have long conversations with the IMGs, kaumatua and staff.

I would also like to offer my sincere thanks to my supervisor, Dr Pita King. Pita has been a constant source of encouragement, knowledge and perspective, who has improved my ability as a researcher. Our supervision meetings helped to keep me centred and focused when I was getting 'lost in the weeds'. I'd also like to acknowledge the ever-present friendship of my Monday Night group. I'd lastly like to thank my whānau, particularly my wife Lucy and our kids Isabella and Frank for their constant love, support and above all, patience.

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Chapter One: Introduction

Conceptualisations of Health

Engel (1977) viewed medicine as a corrective response to a body that is experiencing "changes in physical appearance that frighten, puzzle, or awe, and by alterations in functioning, in feelings, in performance, in behaviour, or in relationships that are experienced or perceived as threatening, harmful, unpleasant, deviant, undesirable, or unwanted" (p. 130). The interest in finding solutions to these changes has persisted throughout human history and occurred across many cultures (Engel, 1977). However, differences begin to occur across cultures in how these diseases are experienced, recognised and potentially treated. How individuals experience illness, seek remedies for poor health and conceptualise wellbeing are all shaped by how different cultures explain reality (Lo & Stacey, 2008). As I seek to explore within this thesis, within the context of Aotearoa New Zealand, health and illness are not experienced uniformly among the population. Numerous pieces of research highlight the inequities of Māori experiences within the health care system (Reid & Robson, 2000; Harris, Tobias, Jefferys, Waldegrave, Karlson & Nazroo, 2006; Goodyear-Smith & Ashton, 2019) often citing the monoculturalist approaches to indigenous health as primary factor. Promoting purely Western biomedical treatments acts to invalidate indigenous realities, including the necessity of more holistic or interconnected worldviews. These conceptualisations of health are dynamic and are shaped by historical, social and political factors. This next section will begin by examining the history, tenets, and limitations of Western biomedicine, before contrasting it with the biopsychosocial, indigenous and Māori models of health and wellbeing.

Biomedicine

Biomedicine has become the most dominant model of disease internationally (Engel, 1977; Larson, 1999). Advances in biomedicine have seen some significant advancements in the treatment of disease, such as the development of antibiotics like streptomycin and the treatment of tuberculosis (Quirke & Gaudilliere, 2008). These successes have been buttressed by the socio-political pre-eminence globally of Western countries and the ongoing effects of colonialism on science globally (Anderson, 2014). Biomedicine was developed from an analytical, science-based model of disease that supplanted or eclipsed other models of health. This approach is concerned primarily with the treatment of somatic variables (Engel, 1977).

Somatic variables involve the isolation of biological symptoms that have variated from measurable norms. The focus of biomedicine is to treat disease in isolation of the social behaviour of a patient. The treatment of disease within the "scientific paradigm of modern medicine, are abnormalities in the structure and function of body organs and systems" (Eisenberg, 1977, p. 9). The development of this tradition is embedded in Western philosophical movements such as Empiricism, Rationalism and Positivism.

The foundations of Western medicine began with Classical Greek thought and were built on during the Late Roman Empire (Nutton, 2005). Hippocrates of Kos, known as the 'father of medicine', developed early theories around disease causation and treatment that influenced medicine until the Renaissance (Grammaticos & Diamantis, 2008). Galen's findings on physiology, which increased understanding of bodily functions such as peripheral nerve systems, were supplemented by a furthering of Hippocrates Humoral Theory (Nutton, 2005). The influence of Galen's Humoral Pathology continued from his death in 200AD to the Mid-Eighteenth Century (Baronov, 2008). This stagnation in the advancement of Western medical science was due in part to the influence of the Roman Catholic Church, leading to a lack of change in medical thought after Galen (Nutton, 2005). Critiques of Galanian medicine began to occur around the 15th century however, as academics like Paracelsus began to shift the medical discourse from rationality and tradition to observation (Baranov, 2008).

The history of modern medicine in the Western tradition is underpinned by the belief that mind and body function as separate entities (Eisenberg, 1977). As envisaged by Descartes, mind-body dualism is the separation of the material body from the mind (Larson, 1999). The rendering of the human body into a "…soulless mortal machine capable of mechanistic explanation and manipulation…" (Kirmayer, 1988, p. 59) allows for the complete focus on the physiological aspects of disease. This concept was championed by enlightenment thinkers who argued that nature could be explained by breaking entities down into 'isolable causal chains' (Engel, 1977, p. 131). This analytical approach rendered the body as a machine made up parts that could be addressed by physiological interventions.

In contrast to the Rationalists, who concerned themselves with the metaphysical, Empiricist philosophers ignored the emphasis on *a priori* deductive thinking and concentrated on drawing

inductive conclusions from the observable world around them (Markie & Folescu, 2004). Motivated by Francis Bacon's theoretical advances in Natural Science and Isaac Newton's successes, Empiricist thinkers were able to consider reality from a bottom-up perspective, thereby opening up natural science by encouraging new areas for exploration (Glass & Hall, 2008). The Royal Society of London for Improving Natural Knowledge led Europe in developing medicine based on Natural History during the 17th century (Wilson, 1995). Sydenham's emphasis, on the categorisation of disease along with treatment that targeted the part of the body that was adversely affected influenced future nosology's and secured Western medicine's place within the Scientific Revolution (DeLacy, 1999).

While the 18th century saw a slowing down of scientific advancement, the increase in public hospitals during the 19th century, contributed to more cases, which encouraged significant growth in disease categorisation. Emil Kraepelin, an important figure in the development of the nosology of psychiatry was thought to believe that "…man is nothing but a part of nature, and, consequently, anything man can do is a product of this natural existence" (Hoff, 2015, p. 34). Kraepelin was reinforcing his belief in Naturalism and the scientific method. Clinical approaches, driven through the growth of research universities, emphasised this Positivist approach that "...relied on the hypothetico-deductive method to verify *a priori* hypotheses that are often stated quantitatively, where functional relationships can be derived between causal and explanatory factors (independent variables) and outcomes (dependent variables)" (Park, Konge & Artino, 2020, p. 690). The current dominance of biomedicine globally is due in part to the primacy of scientism (Mehta, 2011). Scientism was developed from the Positivist school of thought where the world is understood through measurement and observation, which is meant to be unbiased and unsympathetic. Scientism can be considered a dogma whereby "the belief that scientific method was the only legitimate path to knowledge." (Mehta, 2011).

The use of modern biomedical practices gathered momentum post World War II and progressed closely with the development of public health services such as the NHS in the UK (Quirke & Gaudilliere, 2008). Biomedicine has driven medical research and in return, medical research has exerted more and more influence on healthcare delivery (Quirke & Gaudilliere, 2008). In being able to define disease as a measurable entity when compared to a person's subjective experience of illness, public health agencies were able to allocate funds in a manner that was seen as efficient (Larson, 1999). This reactive approach to managing disease at a

population level has led to a deemphasis on preventative medicine (Larson, 1999) and increased ameliorative responses. While there have been numerous notable advancements in biomedicine that have improved the lives of individuals globally, there are limitations in this model that impact upon patients experience of health (Quirke & Gaudilliere, 2008). The increased reliance of western medicine on technology tends to reduce patients to technological objects and physicians to technocratic managers'' (Frankford, 1994, p. 776)

Engel (1977) criticises the reductionist and mechanistic nature of biomedicine while acknowledging the benefits and successes. Limiting health to just the diagnosis and treatment of disease without acknowledging individuals wider social contexts is a consistent critique of biomedicine (Engel, 1977; Larson, 1999). At the heart of this criticism is an epistemological difference between the subjective experience of illness and the objectifiable classification of disease. In a medical context reductionism is "…often equated with older conceptions of disease as something that can be separated from the sick person and scrutinized with successively finer analytic tools" (Greene & Loscalzo, 2017, p. 2494). Social medicine theorists such as Virchow, Dubos and McKeown argued that social contexts had significant effects on who was affected and how they experienced that disease (Townsend, Phillimore & Beattie, 2023).

For many indigenous people, disadvantage is further entrenched through the Positivist assumption whereby "biomedicine isolates and separates the patient from his/her social world via the doctrine of specific etiology" (Baronov, 2008). By focusing purely on the disease, wider causes created through colonialism, such as poverty, are erased as determinants of health. As noted by Reid, Cormack and Paine (2019) doctors' risk "reinscribing racism and coloniality in the way in which we understand Indigenous health and therefore plan interventions" (p. 123). These authors point to the importance of remembering the structural factors that create inequity rather than a narrow focus on individualised risk factors and behavioural change. When illness is placed without the structural context of material disadvantage social hierarchies are reinforced and health inequity is promoted.

Biopsychosocial Model

The Biopsychosocial Model was developed by George Engel (1977) in response to the dominant, reductionist biomedical model of illness. Instead of focusing purely on the somatic responses to

illness, Engels proposed a widening of the scope for health practitioners that encompassed psychological and social factors as well as biomedicine. At the centre of the model is the individual's wellbeing, which is then influenced by psychological, social and biological factors, that shape the patient's attitudes (Farre & Rapley, 2017). It can be viewed as a Western form of holism that tries to incorporate a wider range of factors into how the individual experiences health (Dwairy, 1997). This model fits well with the Constitution of the World Health Organisation (WHO) particularly the definition of health as: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1958, p. 459). In theory, this model encourages the health professional to enable the patient to evaluate "…all the factors contributing to both illness and patient hood, rather than giving primacy to biological factors alone…" (Engel, 1977, p. 133).

In the last 40 years health practitioners, particularly Health Psychologists, have attempted to incorporate the Engel's idea's by introducing aspects of biopsychosocial theory into their practice. In support of the biopsychosocial model, Borrell-Carrió, Suchman and Epstein (2004) emphasise: "…self-awareness; active cultivation of trust; an emotional style characterized by empathic curiosity; self-calibration as a way to reduce bias; educating the emotions to assist with diagnosis and forming therapeutic relationships; using informed intuition; and communicating clinical evidence to foster dialogue, just the mechanical application of protocol" (p.1), as ways for doctors to improve doctor-patient interactions by embracing a relationship-centred model. The widening of the focus from the pathology to include social and psychological contexts has led to an improvement in some health outcomes. Andersen (2002) conducted a review of biobehavioural treatments for cancer sufferers and highlighted several studies that illustrated some success with diet and exercise interventions.

The principal critique of the biopsychosocial model is that it is too vague and generic (Farre & Rapley, 2017). Practitioners sometimes struggle to put it into practice because there is very little detail on how to extract biopsychosocial data (Suls & Rothman, 2004; Farre & Rapley, 2017). It has been described as more of a way of thinking about health, rather than as a model with practical application (Marks, 2002). The need for a multi-disciplinary approach that captures the breadth of factors involved in wellbeing is seen as an area that would help in practically applying the biopsychosocial model (Suls, Krantz, Williams, 2013). Another criticism of the biopsychosocial model is that it acts as a critique of biomedicine while remaining firmly

tied to a positivistic paradigm. The attempts at "…guiding parsimonious application of medical knowledge to the needs of each patient" (Borrell-Carrió, Suchman and Epstein, 2004, p.1) appear to still give primacy to biomedical outcomes, only now delivered with a mere nod towards holism.

This critique does not dismiss the need for empathy in practitioner-patient interactions, but more highlights that the tenets of the biopsychosocial model do not attempt to address wider environmental causes, it often just acknowledges them. This lack of detail in the model itself is a long-held criticism of its practical application (Stam, 2000). Several authors view biopsychosocial theory as a work in progress that broadly encapsulates a positive approach to health without currently offering much of concrete use (Lyons & Chamberlain, 2006). Chamberlain and Spicer (1996) suggest the lack of integration between the 'social' and 'psychological' as an issue. The social aspects of health and how they shape both individuals and community's experiences have become a focus for health professionals who are looking for solutions outside of traditional Western approaches. Expanding the scope of the practitioner to include wider social contexts in their patient's lived experience, is in some ways a passive approach to acknowledging how the social determinants of health play a vital role in health outcomes.

Social Determinants of Health

The Social Determinants of Health (SDH) emphasise the importance of the wider environment on health outcomes for populations (Braveman, Egerter & Williams, 2011). This theory gained support through the work of Thomas McKeown (1976) after he linked positive historical health trends with societal advancements like having access to clean drinking water, nutrition, and sanitation (Braveman & Gottlieb, 2014). McKeown (1976) found that the expansion of living conditions from the mid-19th century to most members of society had steady improved mortality rates before the development of "modern care medical modalities" (Braveman & Gottlieb, 2014, p. 129). This decreased the perceived importance of biomedical practice as the sole arbitrator of health. In the subsequent years, a number of studies have been done that support the role that SDH plays in understanding and approaching population health (Lynch & Smith, 2005; Lönnroth, Jaramillo, Williams, Dye, 2009).

An important initial finding concerned how gradients in socio-economic wealth correlated positively with improved health outcomes. As Hodgetts, Stolte and Rua (2016) note: “These gradients reflect the ways in which individuals and groups are ranked according to power, processes of colonisation, access to resources, life chances, and social status” (p. 425). The wealthy having better outcomes than the poor was far less surprising than the steady, incremental, descending steps from the wealthiest to the poorest members of society. These gradients still occurred in countries like the United Kingdom or New Zealand where the whole population had equal access to health care (Adler & Snibbe, 2003). These findings occurred at a time in global health research, where individual behavioural change was the dominant direction in health promotion (Robertson, 1998). This led to many concerns, including the rise of healthism where the individual is morally compelled to live a healthy life irrespective of wider environmental issues that they have little control over. In contrast to this individual focus, SDH research studies the effects that societal inequity has on the health of the populace.

The reasons behind the importance of SDH to health and wellbeing are multifaceted. The ‘down-stream’ effects where causality can be witnessed over shorter periods of time, are relatively clear (Braveman, Egerter & Williams, 2011). An example of this would be children developing asthma in damp, poorly insulated houses and thereby having a greater exposure to respiratory complications, when compared to children living in drier houses. These associations can be viewed in other environments, with similarly clear causality (Braveman & Gottlieb, 2014). The effects of stress are likely to be a factor in the creation of gradients across different Socioeconomic Status (SES) levels. The increase in life stressors brought about by economic insecurity have profound impacts on individual’s health. Stressful environments can lead to increased allostatic loading which is a “multicomponent construct that reflects physiologic changes across different biological regulatory systems in response to chronic social and environmental stress” (Braveman & Gottlieb, 2014).

The ‘upstream’ effects consist of the macro level factors that create barriers to health and wellbeing such as education attainment and social participation (Braveman & Gottlieb, 2014; Marmot, 2005). Marmot (2005) was at pains to deemphasis SES as a sole cause for the inequitable distribution of health outcomes and highlighted social deprivation as a key determinant. Researchers have struggled to pinpoint exactly how these upstream effects relate precisely to SDH, “…based in part on the complexity of the causal pathways and the long time

periods during which they often play out" (Braveman & Gottlieb, 2014, p. 26). However, while the specificity of the linkages may be hard to quantify, distal determinants that cause inequality in health across populations are none the less present (Czyzewski, 2011). The unfair distribution of 'power, wealth and resources' (Czyzewski, p. 1) are key causes of the unequal conditions experienced across societies.

For Indigenous peoples, the history and ongoing effects of colonialism are a distal determinant of health (Czyzewski, 2011). The impacts of colonial legislation, assimilatory policies and the suppression or loss of native ways of being have created an environment where indigenous peoples carry a disproportionate social burden (Axelsson, Kukutai, Kippen, 2016). These 'up stream' effects are often expressed in terms of lower socio-economic status and the consequential effects of being near the bottom gradients within society. Downstream effects such as experiencing racism and discrimination are individual stressors that have direct impacts on health and wellbeing. The effects of SDH on Indigenous populations are often exacerbated by Western health systems that are orientated towards individualistic understandings and approaches to health as opposed to the more holistic notions evident among indigenous communities (Nelson, 2014). Building on the effects of SDH, the next section will focus on how practicing Indigenous conceptualisations of health, encourage 'human flourishing', and alleviate some of the effects of historical inequality in health for Indigenous peoples (Paradies, 2016).

Indigenous Health

Healthcare as experienced by members of Indigenous populations living as minorities in colonised, developed countries, is dominated by Western conceptualisations of health (Hart, 2010). Biomedicine, the Biopsychosocial model and SDH are all theories that are embedded in a Western paradigms. While Indignity is a universal term that consists of many different worldviews, there are commonalities in belief that can be drawn upon as a collective response to colonisation (Sium, Desai & Ritskes, 2012). The disruption of traditional ways of being due to the imposition of Western monoculturalism, for example, is a common theme in the analysis of indigenous health. In this next section I will address these broad commonalities in Indigenous conceptualisations of wellbeing and discuss how dominant group understandings of health affect indigeneity.

Indigenous peoples suffer from health inequities globally (Marmot, 2005; Gracey & King, 2009; Reid, Cormack & Paine, 2019). As stated by Kirmayer, Brass & Tait (2000):

> *"Around the world, indigenous peoples have experienced rapid culture change, marginalization, and absorption into a global economy that has little regard for their autonomy. The differences between these indigenous peoples may affect the nature of these gaps and how they are experienced by each culture, but the root causes and subsequent challenges involve similar themes." (p.607)*

Axelsson, Kukutai and Kippen (2016) cite Czyzewski (2011) in arguing that colonialism should be treated as a distal determinant or underlying 'cause of causes' (p. 3) of Indigenous health. A response to the ongoing effects of colonialism by indigenous cultures has been to reassert their own conceptualisations of health and wellbeing. These conceptualisations are enmeshed in the distinct cosmologies of these peoples and are often interconnected with spirituality, relationships and both cultural and natural resources (Magallanes, 2015). All these cultures share differences as well as similarities, but health perspectives have been shaped by colonization and shared indignity has "evolved into a powerful notion that there exists a distinct category of peoples in the world distinguished by having been socio-politically marginalized" (Kirmayer, Brass and Tait, 2000, p. 611).

The pathologizing of the indigenous experience within a colonial context is a concern across many colonized peoples. There is a danger in applying deficit-based discourse to indigenous health research, without the broader context of the effects of colonization (Hyett, Gabel, Marjerrison & Schwartz, 2018). Negative health statistics in isolation, potentially generate narratives that further burden cultures who suffer from historical stigmatization (Hyett et al., 2019). Within this context of cultural, material, and social loss however, the disparity in health outcomes between settler populations and indigenous peoples is significant. Historically, these discrepancies in health have contributed to severe population declines for Inuit (Kral, Idlout, Minore, Dyck & Kirmayer, 2011); Indigenous Australians (Hunter, 2007); and Māori (Durie, 1999).

Assimilatory policies enacted by colonial governments have ensured that Western realities have been enforced upon indigenous peoples. Theories of health, based on positivist assumptions, such as biomedical practice, contrast poorly with many indigenous worldviews. Indigenous

cultures consist of distinct characteristics and differences due to “varying degrees of dispossession, different health experiences and diverse political relationships” (Durie, 2004). There are, however, some commonalities that broadly exist across indigenous peoples that colonization has impacted upon. Examples such as the importance and subsequent loss of land; the breakdown of traditional social structures; and the loss of cultural identity have commonly affected indigenous wellbeing internationally (Hart, 2010).

As a consequence of colonization indigenous cultures have had to fight against the subjugation of traditional ways-of-being (Reid et., al, 2019). The framing of Eurocentric thinking as progressive, while indigenous thinking is stuck in the past is the consequence of myth making that predates modern colonialism (Battiste, 2005). There was (and continues to be) a renaissance in indigenous ways-of-being globally during the 1960s and 70s, where some cultures reasserted their right to strive for wellbeing on their own terms (Hill, 2010). Many indigenous health models maintain an emphasis on holism as the centre of their worldviews. These models are dynamic however, and have the capacity to change and embrace new, relevant information. Western medicine, for example, has a place in many indigenous health models (Lock, 2007; Pitama, Huria & Lacey, 2014).

The loss of tribal land to colonization has effects on indigenous populations that often extend beyond material loss. Durie (2004) emphasised having a strong relationship with the environment as a defining trait shared by indigenous peoples. The link between identity and the land is central to this relationship as a feature of a holistic outlook where people and the environment are all interrelated aspects of creation (Durie, 2004). Within this world view the loss of ties to tribal land is constructed as trauma. Holism extends from the land to relationships with both wider family groupings and often ancestors. Interrelationships are central to many indigenous peoples and viewed as a protective factor in maintaining wellbeing (Mohatt, Rasmus, Thomas, Allen, Hazel & Hensel, 2004).

The colonization on indigenous populations effects health outcomes and quality of life in a number of ways, that are located within a ‘broader socio-political context’ (Axelsson, Kukutai & Kippen, 2016). Mainstream analysis has made the mistake of concentrating on individual-level behaviour change rather than systemic issues (Axelsson et al., 2016). A lack of acknowledgment

of the ongoing nature of colonization is partially to blame for this limited focus. Colonization is often framed as something static, that happened in the past (Alfred & Corntassel, 2005). An analysis of the proximal determinants of health might look at these surface issues without delving much deeper. Health promotion targeted towards changing individual behaviour such as smoking cessation, is indicative of an approach that fails to address the deeper contextual issues of colonization (Kirmayer, Simpson & Cargo, 2009).

Analysis based on the distal determinants of indigenous health attempt to locate how historical trauma is reproduced in the indigenous experience. This trauma is often maintained through systemic racism that is found within government policy approaches that are still based on colonizing world views. Barriers, such institutional racism have been maintained throughout colonisation and undermine efforts in tackling health inequity (Henry, Houston & Mooney, 2004). In a study of the disparity in eye health cases amongst Indigenous Australians, Yashadhana, Fields, Burnett and Zwi (2021) pointed to linguistic, economic, and cultural marginalisation as barriers to equitable outcomes. The barriers created by systemic racism, such as the Aboriginal Act of 1905 or the displacement of Indigenous Australians from their land "…has had far reaching consequences on Aboriginal health and social and emotional wellbeing" (Parker & Milroy, 2014, p. 25).

Indigenous cultures share commonalities that form the basis for global relationships that add collectively and empowerment to the attainment of overall indigenous health goals. The recent Draft Resolution of the Health of Indigenous Peoples is testament to those partnerships. However, severe disparities still exist, and the consequences of ongoing colonialism persist. Each indigenous culture has its own unique contexts that shape the nature of these health disparities. In the next section I will discuss the unique context that shapes modern conceptualizations of Māori health in Aotearoa New Zealand.

Māori Conceptualisations of Health

Māori conceptualisations of health are shaped by the interrelationship of people, the land and spirituality (Durie, 1994). Prior to colonisation, life expectancy was relatively young when compared with modern data, but approximately in keeping with the global norms of the time (Kingi, Durie, Elder, Tapsell, Lawrence, Bennett, 2018). The population is thought to have grown

steadily from the initial wave of settlement from Polynesia circa 1200-1300 CE until British colonisation in 1840 CE (Durie, 1999). Māori settlements were organised to minimise broader health risks and many of the fundamentals of successful public health systems, such as clean drinking water, were practiced (Lange, 1999). The health of the community was the priority and rules were in place that reinforced the "interests of the group as a whole" (Durie, 1999, p. 7). A relatively high level of hygiene in Māori settlements is evidenced by both pākehā missionaries such as Samuel Marsden and contemporary Māori voices such as Māui Pōmare (Lange, 1999). Challenges to health and a low life expectancy were often due to a lack of reliable protein and by extension, malnutrition (Lange, 1999).

Conceptualisations of health for Māori in pre-colonial Aotearoa were underpinned by a combination of interrelated pragmatism and spirituality (Durie, 1999). As a collectivist culture, maintaining health was in concordance with group harmony and overall balance. As with many other indigenous cultures, Māori applied a holistic approach to health that incorporated the individual's broader context into considerations of ill health. Any imbalance was viewed as a potential cause of mate atua, or ill health, brought on by malevolent spirits (Buck, 1910). Contrastingly, Mate tangata or temporal illness such as fracturing bones were treated in a "matter of fact manner" (Durie, 1999, p.17), that emphasises an approach to overall health that was both spiritual and practical in nature.

The relationship between tapu and overall health was an example of spirituality as a social control (Durie, 1999). The population were protected by the designation of unhealthy environments as tapu. The categorisation of water quality across both spiritual and practical realms underlines this point. On initial contact, missionaries and anthropologists may have romanticised the more mystical aspects of tapu while ignoring these practical implications. Māori attitudes towards disease may have been seen as a 'moral problem' (Lange, 1999), but only because the morals themselves were based on practical health policy. For example, a tohunga may have used a diagnostic process that was "…directed at uncovering any breach of tapu so that the somatic reaction might be better understood" (Durie, 1999, p.15). A case of dysentery, caught from a stagnant pool, that was categorised as waikino, literally 'bad water', would provide a tohunga with key information.

The fundamental world view that defined tangata whenua during the pre-colonisation period is still at the heart of current conceptualisations of Māori health today. However, from initial contact to depopulation, disease and warfare, through to a renaissance in cultural identity, Māori have faced the effects of colonisation on our collective wellbeing. The next section will examine how Health policy in Aotearoa New Zealand has developed along with the ongoing effects of colonisation to shape current Māori attitudes towards health provision.

This History of Health Policy in New Zealand

In my previous sections, I explored a range of ways in which the notion of health has been conceptualised along diverse sets of ideas, assumptions, and cultural norms. However, such ideas are often wrapped up with issues of power, by extension, the ability to impose these conceptualisations of health throughout service provision. For this reason, it is important to explore the ways in which health policy within Aotearoa/New Zealand has developed alongside the broader processes of colonisation that perpetuated monoculturistic conceptualisations of health.

The policy choices made by New Zealand Governments since 1852 have often shaped Māori health by creating and reinforcing the ongoing negative effects of colonisation (Came, 2014). Within a relatively brief time, the state of Māori health has fluctuated from severe depopulation to steady population growth, that has been accompanied by a lower standard of health than experienced by non-Indigenous New Zealanders (Pitama, Huria & Lacey, 2014; Reid, Cormack & Paine, 2019). The reasons for these discrepancies are associated firstly with a period of collective Māori flux, where the arrival of settler culture created an environment where the uncertainty between traditional and European practices led to the worst of both worlds (Durie, 1999). From first contact to the present, a constant theme in indigenous health has been the tension between government led monocultural policies and the desire of Māori to express self-determination, encapsulated by the term Tino Rangatiratanga.

The Early Colonial Period

In the early stages of European settlement, post 1800 CE, both Europeans and Māori looked positively on the state of indigenous health and the potential for new ideas to augment current practices (Durie, 1999). The state of Māori health was said to be strong when the first

Europeans encountered the indigenous population (Durie, 1999). Life expectancy was low, but the population was considered to be "…physically robust and generally in good health" (Lange, 1999, p. 2). The population at the time is difficult to estimate and ranges widely from 100,000 to 500,000 (Durie, 1998). Māori were open to new ways of doing things initially and sought to embrace some of the new values being presented (Durie, 1999). This initial optimism was not to last long, as the negative effects of first contact began to have drastic consequences for the Māori population.

By the 1830's it was evident to many onlookers that Māori health had undertaken a significant downturn (Durie 1998). While the exact estimates of the extent of depopulation are difficult to estimate, due to the inaccuracy of contemporary methods, it is generally agreed that there was a precipitous and almost calamitous decline in the Māori population (Lange, 1999; Durie, 2000). The request of British Resident James Busby in 1937 for an intervention by the Crown in the governance of New Zealand, in the form of the Treaty of Waitangi, was driven in part by his concern about overall Māori health and the subsequent rising mortality rate (Durie, 1998). Further policy interventions by the newly formed New Zealand government, exacerbated this crisis for the rest of the century.

Durie (2005) highlights the English Acts Act (1854) as an example of a policy that set the tone for the governments approach to Māori health in early colonial New Zealand. This act is an example of how intent and practice often lead to contradictory results for early lawmakers. The intent in this initial legislation was to offer protections to the indigenous population against scurrilous acts by settlers (Durie, 2005). In practice, settlers were far more accustomed to the manipulation of laws that were enmeshed in their culture, resulting in an intensifying of indigenous exploitation. Durie (2005) links the expression of English law as the evolution of common law, which accommodated the reproduction of English culture. The dual consequence of this act was that it placed the British worldview as universal and normalised, while presenting Māori worldviews as the problem. This worldview, whereby Pākehā cultural norms stand as the natural order perseveres in modern New Zealand (Borell, Gregory, McCreanor, Jensen, Moewaka Barnes, 2009). This imposition of British culture on Māori ways of being created an environment that led to the breakdown of Māori authority and (by extension) the weakening of the system of tapu and noa that were the foundation of pre-colonial Māori health policy (Hill, 1994).

The use of Western science to pathologize Māori, helped to shape modern deficit framing in health and education (Bishop, 2005). The relentless drive for land and the subsequent assault on Māori material and cultural possessions were blamed on the inability of Māori to assimilate into the perceived more advanced way of life (Bishop, 2005). While many iwi had displayed an aptitude for wide scale agriculture and commercialism, whilst maintaining a collectivist social structure, military subjugation led to a new colonial narrative that painted Māori as unable to cope with healthy acculturation. These arguments were often supported by Western scientific theories (Lange, 1999). For example, explaining the high incidence of Māori deaths via respiratory diseases on "weak lungs" was a "…way of legitimizing colonisation and impersonalising settler culpability" (Lange, 1999, p. 59).

The illegal confiscation of Māori land via government policy had a significant effect on Māori health. The New Zealand Settlements Act of 1863 and the ratification of these laws through the establishment of the Native Land Courts in 1965 led to Māori officially owning none of the South Island and 40% of the North Island (Controller & Auditor-General, 2011). A bond with the land is central to our conceptualisations of health and wellbeing. In providing an environment where British ways of being thrived, the government was able to encourage individualism at the detriment of the traditional collective (Durie, 1998). This disruption of the people from the land has ramifications that continue to the present and beyond because "Mana whenua is about the links between tribal strength, integrity and survival. It remains a source of both bitterness and pride" (Durie, 1998, p. 36). As the group responsibility that came with land ownership deteriorated, so did Māori society. The loss of land also meant a loss of income and self-sufficiency, as disenfranchised Māori were forced into a Western dominated society that was inherently unequal. Accompanying the social and spiritual loss of land came an economic positioning that placed the Māori population at risk of the same SDH that affect the most deprived people globally (Moewaka Barnes & McCreanor, 2019).

The Early 20th Century

Towards the end of the nineteenth century, state intervention towards Māori health was extremely limited (Lange, 1999). The steady depopulation had many Pākehā thinkers discussing a 'managed decline' of the indigenous population that would inevitably lead to extinction (Durie, 1998). Early attempts at addressing Māori health centred around our assimilation into Western culture. These efforts were in affect half-hearted, which was reflected in the general

underfunding of most Indigenous health efforts (Durie, 1999). Successes at this time were often due to the extraordinary efforts of individuals who succeeded despite funding limitations. The efforts of some teachers in Native Schools, where: 'Health education, both theoretical and practical, was a continuing emphasis on the system…' (Lange, 1999, p. 76) was an example of this individual application. Many of these interventions however came with a dual purpose. In the case of Native Schools, the purpose was to 'civilize' by enforcing the English language and culture, while offering advice on health (Bishop, 2005).

A turning point in the nearly catastrophic mortality rate of Māori through the nineteenth century occurred when Māori doctors began to use the structure of government and Western health approaches to instigate change on a population level (Durie, 1999). These graduates of Te Aute College such as Āpirana Ngata, Peter Buck and Maui Pomare used Western training to collectively improve the living standards and attitudes of the wider indigenous population. Durie (1999) points out the contrasting strategies of these pioneering Māori doctors towards health promotion that diverged over the level of Māori autonomy. Broadly, Māui Pōmare and then Peter Buck attempted to use a monoculturalist approach to work within the system and improve Māori hygiene standards. Pomare worked with the newly established Department of Public Health and the localised mana and knowledge of the Māori Councils to successfully roll out health policy across Māori communities. Eventually, this progress was stymied by the marginalising of the Māori Councils as generators of policy (Hill, 2009).

The Tohunga Suppression Act (1907) exemplifies assimilationist health policy of that time. As Laing and Pomare (1994) note: "The Western medicine of the settlers in the colonies was informed by the concept of amalgamation, which was translated into a government policy of assimilation" (p. 145). This Act outlawed Tohunga from performing practices that had been used to treat Māori communities for centuries. Durie (1999) frames the passage of this act as having political motivations while acknowledging how both Pōmare and Buck supported the Act. For these Western trained doctors their belief in the inability of Tohunga to treat epidemics such as tuberculosis, made them counterproductive in tackling disease in the colonial period. The prohibition of Tohunga may have been used as a tool of the state against the prophets such as Rua Kēnana, who was urging Māori to expel Pākehā from New Zealand (Durie, 1997). Either way, the stated purpose of improving Māori health was undermined by limiting of Māori self-determination.

The Mid-20th Century

Having averted the worst of the health crises, the Māori population steadily increased through the middle of the twentieth century (Durie, 1999). New Zealand's participation in World War II created an opportunity for Māori to internally organise and participate, while ultimately aiding the country's objectives. The Māori War Effort Organisation was the driving force in this collective action (Hill, 2009). Many viewed this newfound acceptance within mainstream culture as a potential starting point to develop Māori autonomy. These local tribal committees had the potential to improve community-based welfare on Māori terms. However, by the end of WWII, Māori had lost control of their own health provision and the steady push towards assimilation continued (Orange, 1987).

Then Māori Social and Economic Advancement Act (MSEA Act) 1945 was the culmination of the political leverage gained by Māori post WWII (Hill, 1994). A combination of factors including urbanisation and a rapid population growth had increased the importance of the Māori vote. The MSEA Act was seen as a compromise that offered Māori equality with Pākehā. In practice the Act was a tool of an overarching assimilatory policy that minimised indigenous autonomy by limiting the scope of tribal committees through the creation of the Māori Welfare Office. There were positive outcomes for some Māori communities that made improvements to their communities with a small amount of Ministry of Māori Affairs money and significant local participation (Hill, 2018). However, the funds were limited and while the government allowed some forms of Māori identity to survive, the bigger picture was relentlessly assimilationist. An example of these monoculturalist policies was 'pepper-potting' where Māori families were housed and isolated within cities away from other hapu members (Hill, 2012). Hill (2009) highlights a Ministry of Māori Affairs publication that described the 1945 legislation as the 'most important single step ever taken in the progress of the Māori people towards complete integration with the pakeha way of life' (p. 18)

As the power of the committees waned; two Māori organisations helped to maintain some autonomy in health. Te Rōpu ō Te Ora (The Women's Health League) was instigated in Rotorua by Robina T Cameron, a district nurse who was looking for strategies to address the high maternal and infant mortality rates (Durie, 1999). Health committees were set up, outside of traditional government structures that had a remit to build relationships between Māori and European women, offer advice about raising children, edible gardens and cooking, while

reinforcing the importance of traditional practices and relationships with marae (Durie, 1999). The Māori Women's Welfare League was set up on the advice of Rangiātahua Royal, the Controller of Māori Welfare. These nationwide committees were viewed as a continuation of earlier tribal councils but focused on health and welfare. The goals of the Welfare League were very similar to the Health League with an early emphasis on "…the establishment of accessible and culturally relevant health clinics" (Durie, 1999, p. 49). Both organisations offered support to a people facing a rapidly changing social environment. Both Leagues fought for autonomy, but resistance to their mutual government departments underlines the continued distrust of the New Zealand government and their desire to allow Māori health to develop under Māori control.

1975

While health outcomes for Māori had improved over the century, the gap with Pākehā health outcomes had not narrowed. Durie (1999) names 1975 as a watershed year in which Māori began "reclaiming an active role in health and health care" (p. 52). Through the 1970's and 1980's Māori began to lose faith in Western methods of treatment. A new 'epidemiological era' brought about a rise in multi factorial illnesses that couldn't be treated easily by purely medical means (Hill, 2009). There were very few magic bullet solutions for health behaviours that arose from wider environmental factors created via ongoing colonialism. Approaches to population health that had brought success at the turn of the century for diseases such as tuberculosis, were ineffective in addressing illnesses related to the social determinants of health. This growing mistrust was exacerbated by the growing financial inaccessibility of primary health care. GPs had kept a foot in private healthcare since the Social Security Act (1938) and the Government's subsidies had not adjusted with inflation, leading to steady fee increases (Brown and Bryder, 2023). The combination of many Māori living in low-income households and historically high GP fees led to less overall treatment.

Both the Labour and National governments had paid lip service to tackling disparities in health while keeping Māori leadership at arm's length (Hill, 2009). The Labour white paper 'A health service for New Zealand' (1974) discussed equitability without making any provision for Māori, while National's Health Services Organisation (SANCHSO) contained no Māori representation amongst 19 appointed board members (Brown & Bryder, 2023). In response to a continuation of ineffectual New Zealand government health policies, Māori began to exert power outside of

the confines of the mandated spaces that we had been limited to (Pihama, Cram & Walker, 2002). The Land March led by the original president of the Women's Welfare League, Whina Cooper, The Treaty of Waitangi Act (1975), Waitangi Tribunal, a Māori language petition to parliament and the occupation of Takaparawhā encouraged a resurgence in collective Māori identity (Pōmare, Keefe-Ormsby, Pearce, Reid, Robson, Wātene-Haydon, 1995). This wave of dissatisfaction with the status quo brought about an increased focus on Māori health and education.

Rapid urbanization from the 1950's had increased the visibility of the disparity in Māori and Pākehā living conditions (Hill, 2009). The break from often rural, tribal lands had detrimental effects on Māori health and cultural identity as the city-born generations struggled to remain connected to Māori ways-of-being (King, 2019). From the new urban malaise, however, came different Māori organisations that raised awareness of the detrimental effects of colonialism and the failure of the government to meet the obligations of the Treaty of Waitangi. These obligations had been invalidated by judge James Pendergast in 1872 and generally forgotten by the government up until the late 1970's when protest groups such as Nga Tamatoa (the Young Warriors), began to demand autonomy (Paquette, 2012). The rising demand for equality and a bicultural approach to governance led to the Waitangi Tribunal Act (1975) and the subsequent formation of the Waitangi Tribunal to rule on treaty claims. A raised awareness of the desire for tino rangatiratanga (self-governance) in combination with new power derived from the Waitangi Tribunal Act encouraged Māori leadership to conceptualise health initiatives that function alongside or outside of the dominant Western biomedical model.

The Working Group on Indigenous Populations formed in 1982 as a sub commission of the Promotion and Protection of Human Rights within the UN (Sanders, 1989). A global focus on Indigenous wellbeing added to the impetus for transformative action. This pressure increased awareness that assimilation policies were disproportionately hurting Māori wellbeing led to a drive to find health solutions that were distinctly bicultural (Thomas & Nikora, 1996). The global recognition of the relationship between health and culture, in combination with the reconceptualization of Article Two of Te Tiriti, as Māori control over Māori health, helped to create a space for Māori to define an overall health philosophy (Durie, 1998). These concepts were placed in the foreground in 1984 firstly at Hui Whakaoranga and then during the launch of the Decade of Māori Development at Hui Taumata (Rochford, 2004). The first hui "…provided an

opportunity for a re-examination of a Māori health philosophy, but also discussed the provision of health care programmes by Māori and strongly advocated Māori health initiatives" (Durie, 1998, p. 53). Many of the principal academics, practitioners and leaders involved in Māori health came together to discuss how Māori health inequity would be approached. Models such as Te Whare Tapa Wha and Te Wheke, highlighted the importance of holistic approaches to wellbeing and the interconnectedness of Body, Mind, Spirituality and Relationships (Palmer, 2004). These models underlined the need for an integrated approach to the interrelated economic, social, and cultural approaches that affected Māori health.

Neo-liberalism

Māori desire for self-determination and control over our health policy was hampered by changes to government and subsequent restructuring efforts (Brown & Bryder, 2023). Māori organisations who had built relationships with particular government health departments found themselves having to repeat the process. These restructured organisations also came with different goals, different funding models and varying attitudes to Māori self-determination (Durie, 1998). The 4th Labour government had begun to implement policies that were in line with Māori self-determination (Hill, 2009). Hill (2009) posits that government policy makers had underestimated the continued importance of tribes to Māori and were surprised when it became apparent that urbanisation hadn't led to mass detribalisation. However, 80% of Māori still lived in cities and for some, legislation such as the Runanga Iwi Act (1990) placed the decision-making processes in the hands of iwi, thereby disenfranchising a significant proportion of urban Māori who were culturally disconnected. This devolution by the government helped to undermine the pan-Māori movement, giving some control of health to Māori, while neoliberal economic policy ultimately provided less funds. Both elements of this approach would have lasting consequences over the 1990's and beyond.

The devolution of decision making from government to iwi, handed over nominal control of Māori health whilst maintaining funding control and by extension power (Smith, 2015). The period between 1985 and 1995 saw a huge growth in the number of iwi health providers many of which were, "under-funded and under resourced" (Durie, 1994). This demand on iwi providers was exacerbated by the negative social and economic conditions that corporatisation and subsequent privatisation were creating. The restructuring of State-Owned Enterprises led to significant job losses in the name of the neoliberal experiment (Larner, 1997). These job

losses disproportionately affected Māori households (Bryder & Brown, 2023). Between 1986 and 1992 unemployment among Māori men had risen from risen from 12 percent to 25.4 percent (Bryder & Brown, 2023). Smith (2015) has characterised the governments interests as 'shifting the burden of responsibility' to Māori communities whilst ignoring their Treaty obligations (p. 23). Over the 1990's the Māori health providers grew and initiatives such as cultural safety guidelines in Nursing and free GP visits for under 6-year-olds, found a place in mainstream policies. Over the same period however, the emphasis on personal responsibility and by extension victim blaming grew in front of a backdrop of poor economic conditions that severely affected the social determinants of health for Māori families (Bryder & Brown, 2023).

The intense implementation, though not the end, of neo-liberal policies finished in 1999 with the election of the 5th Labour government (Bryder & Brown, 2023). The New Zealand Public Health and Disabilities Act (NZPHDA) (2000) was Labour's policy departure from the last decade. Devolution continued with the fourth restructuring of New Zealand health, taking control from the centralised Health Funding Agency and tasking 21 majority elected District Health Boards (DHB) with purchasing, planning and provision (Boulton, Simonsen, Walker, Cumming & Cunningham, 2004). The restructuring ensured that at least two Māori representatives sat on each DHB. The funding of services via non-DHB providers also fell within the DHB's remit. The focus on Māori health by the New Zealand government in the 2000's was on the promotion of social equity with an emphasis on closing the gap in health outcomes between Māori and Pākehā. He Korowai Oranga, the Māori Health Strategy, was the key document that was created to ensure that inequity was addressed. This was the first government social policy document that incorporated Treaty of Waitangi obligations (Boulton, et al., 2004). The legislation aimed to increase Māori participation in health decisions and to ensure that DHB's took responsibility for closing the gap between Māori and Pākehā health outcomes. The initial focus according to Goodyear-Smith and Ashton (2019) was on, "…encouraging cooperation rather than competition between providers, reducing inequities, improving primary health care, shifting services into the community, and strengthening service integration" (p. 433).

The Present

Despite the stated aims of He Korowai Oranga, the gap in health outcomes between Māori and Pākehā has not closed and Māori dissatisfaction with health services has persisted (Masters-Awatere, Cormack, Graham & Brown, 2020). Colonialist attitudes towards Māori health have

been maintained through monoculturalist policies that have failed to fully support Māori led health initiatives (Came, Herbert & McCreanor, 2021). Racism at all levels of analysis is experienced by Māori across national institutions, "individually, collectively and cumulatively" (Came, Doole, McKenna & McCreanor, 2018, p. 132). The emphasis on funding Māori health service providers via DHB's has been undermined by an institutional bias towards non-Māori health care providers (Came, et al., 2020). Came et al., (2020) identify length of contracts and frequency of audits, to suggest institutional racism within the Māori health care provider industry. Short contract lengths make it difficult for providers to plan effectively and offer job security to highly skilled staff. Being audited constantly adds stress to work environments and in combination with high compliance demands, underlines "overt and covert expressions of discriminatory institutional power" (Came et al., 2020). A study of Ngāti Porou Hauora highlighted the poor juxtaposition of mainstream performance indicators upon the needs of Māori communities being linked to ongoing funding as an ongoing issue (Hauora, Gibson, Leach & Coast, 2005).

The dissatisfaction with the application of He Korowai Oranga has ultimately manifested in the initial findings of the Waitangi Tribunal's Health Services and Outcome Inquiry. The first of three reports published in 2019 focused on the Primary Health Care system, while the next two reports will concentrate on: mental health, disability, and tobacco/alcohol/substance abuse; and remaining areas, including historical claims (Came, O'Sullivan & McCreanor, 2020). The first report has acknowledged the failings of the government in the first two decades of the 2000's in upholding the obligations of the Crown regarding Māori health (Came, et al, 2020). A lack of commitment from the government in tackling health inequity in primary healthcare was a core criticism of the findings (Came et al., 2020). This was evidenced by the underfunding for Māori primary health providers, a lack of targeted data collection and the underrepresentation of Māori in both health professions and the Ministry of Health (Brown & Bryder, 2023). In response to this report the Labour government reviewed the governments health policy which resulted in the replacement of the 20 DHB's in 2022, in part with Te Whatu Ora, Health Zealand. Part of this restructuring also involved the creation of Te Aka Whai Ora (the Māori Health Authority).

The future of this restructuring is uncertain, however. The National Party has pledged to disestablish Te Aka Whai Ora at the time of publishing. Shane Reti, the health spokesman for

the National Party has suggested that a return to devolution was the way forward for Māori health (Pointon, 2023). Another period of restructuring would create more instability in Māori health provision and continue a legacy of constant policy changes that have made progress difficult.

Overall, government economic policies have affected different demographics within the Māori population uniquely. A minority of Māori still live in rural New Zealand and macro trends have created barriers to health service provision that are specific to that environment. For Māori living in rural New Zealand, the "excess all-cause and amenable mortality experienced by rural Māori, compared to their urban counterparts, suggests that there are additional challenges associated with living rurally" (Crengle, Davie, Whitehead, De Graaf, Whitehead & Nixon, 2022, p. 1). These unique challenges are often placed at the feet of understaffed medical organisations that rely heavily on International Medical Graduates to maintain health services. In the next section I will outline global medical migration, New Zealand's reliance on IMGs and the barriers that these doctors face post migration.

International Medical Graduates

There has been a long-standing issue with the recruitment and retention of rural GPs in New Zealand (Goodyear-Smith & Janes, 2008). Historically, the New Zealand government's first response to recruitment in deprived rural areas was the Section 82 of the Social Security Amendment Act (1941) that designated some remote rural regions as 'Special Medical Areas' (Cumming, Raymont, Gribben, Horsburgh, Kent, McDonald & Mays, 2005). This designation aimed to improve rural recruitment by providing free accommodation, 3-month sabbaticals, and a salary. These doctors often worked out of rural hospitals (like Rawene in the Hokianga) and provided clinics to the outlying areas in conjunction with district nurses. The packages were targeted in part to recruiting doctors from the UK (Kearns, Myers, Adair, Coster & Coster, 2006). Where once rural hospitals had met rural community health needs by bridging the gap between primary and secondary care, the health reforms of the 1990's eroded services leading to "the withdrawal of specialists from rural hospitals and the downgrade or closure of many facilities" (Blattner, Stokes & Nixon, 2019, p. 2). District Health Boards were handed extra funding in the form of a 'Rural Adjuster' to "adjust for variations in costs associated with providing services to rural communities" (Penno, Audas & Gauld, 2012, p.26). A 'rural bonus' of $4.23 million was

allocated in 2006 directly to rural General Practitioners as a further incentive (Goodyear-Smith & Janes, 2008).

Part of the rural retention issue was addressed by the recognition of a rural health medicine vocational scope by the Medical Council of New Zealand in 2008 (Blattner, Miller, Lawrence-Lodge, Nixon, McHugh & Pirini, 2021). The total workforce for Rural Hospital Medicine specialists has grown from 26 in 2010 to 143 in 2022 (MCNZ, 2022). Workload was viewed across all health professions as a detracting factor of practicing in rural settings (Raymont, Lay Yee, Pearson & Davis, 2005). After hours on-call sessions are often 1 day in 7 and impact on practitioners' family or social lives (Goodyear-Smith & Janes, 2008). Rural GPs have been shown to work longer hours, see more patients per hour and work more weekends on call than any other GP sub-group (Fraser, 2006). These work-related factors, coupled with a perceived lack of prestige in rural practice within hospital training programmes (Kent, Verstappen, Wilkinson & Poole, 2018), has put more pressure on recruitment.

The recruitment of Internationally Trained Medical Graduates to fill rural medical roles has long been a core strategy of the New Zealand state (Zurn & Dumont, 2008). The incentivised financial packages of the Special Medical areas are an example of these policies. Without IMGs working in rural New Zealand towns, the chronic understaffing of many rural practices and rural hospitals would be considerably worse. Currently, IMGs consist of over 50% of the rural GP workforce making New Zealand heavily dependent on other countries to provide medical recruits (Goodyear-Smith & Janes, 2008). This trend in recruitment has persisted for decades and isn't projected to change significantly in the future (Buchan, Naccarella & Brooks, 2011). This dependency on IMGs, places an emphasis on how these doctors are being transitioned into roles that are vital to our communities. The next section will examine how acculturation may affect the practice of IMGs in Aotearoa New Zealand, as well as the international literature on cultural induction within the medical sphere.

Within OECD countries the use of IMGs to fulfill rural medical positions has been steadily growing over the last four decades. Canada (Dove, 2009), Australia (Hawthorne, 2012) and the United States (Hart, Skillman, Fordyce, Thompson, Hagopian & Konrad, 2007), all use IMGs to staff underserved regions, including rural locations. International trends towards globalization

have led to an increased amount of movement between countries medical workforces. This level of migration leads to broader questions about the ease of acculturation and the effects this has on IMGs and the communities that they are working in. The literature shows that many IMGs are moving to new countries to experience better working conditions or lifestyles for their families, not to specifically work in rural locations or practice medicine on Indigenous populations (Gilles, Wakerman & Durey, 2008). The need for IMGs in these areas is exacerbated by how undesirable the locations are themselves to doctors from the host population (Al-Haddad, Jamieson & Germani, 2021). Cities, in many instances are perceived as being the more desirable places to live for doctors trained in the host country. This increases the need for IMGs in rural locations and necessitates thorough orientation policies for new migrant doctors in these communities.

The importance of community buy-in may influence how orientation policies are perceived by IMGs. Looking at the low retention figures nationally, but particularly in rural settings, the lack of longevity in these jobs may reflect the lack of desirability in the locations (Crandall, Dwyer & Duncan, 1990). IMGs are often recruited to hard-to-supply areas, such as rural practices or hospitals that are not able to secure New Zealand trained doctors. The difficulty in rural recruitment and retention of both local and foreign doctors may partly be due to the draw of living in cities. Gauld and Horsburg (2015) surveyed NZ IMGs on the different "push" and "pull" factors in choosing to work in New Zealand and concluded that Quality of Life, more attractive working conditions, and career opportunities were the factors that most motivated overseas doctors. These factors however are based partly on material markers such as renumeration and upwards promotion but as importantly on feeling accepted by the communities that they are working in. How these IMGs acculturate into their new communities' shapes retention and the overall quality of care that practices can offer.

Acculturation Challenges

Migrational adaptation can present challenges that may affect physical and mental wellbeing. Berry, (1992) defines acculturation as "culture change that results from continuous, first-hand contact between two distinct cultural groups" (p. 2). Within a rural New Zealand context, it could be argued that for IMGs the continuous contact occurs with at least two distinct cultures. This may raise the risk of acculturation stress (Berry, 2013), as values, attitudes and norms are challenged. Acculturation strategies involve the ways that migrants look to acculturate into a

new society. Assimilation occurs when the migrant attempts to substitute their original cultural identity with that of the new dominant culture; Separation involves the migrant being forced to or deciding to maintain their cultural identity; and marginalization involves the loss of traditional and dominant cultures as part of experiences of societal alienation (Berry, 1992). For some IMGs entering New Zealand society, the goal is integration whereby they participate successfully in the host culture, while maintaining aspects of their original culture.

There are many factors involved in successful integration into a new culture and IMGs acculturation processes vary accordingly. There are however some consistent factors that create challenges and act as stressors for IMGs. Some of these factors involve work specific challenges, while others are stressors faced by migrants irrespective of employment. Outside of providing culturally appropriate care for indigenous populations, IMGs are having to adapt to different medical cultures, registration processes, language barriers and national health framework. Qualitative studies of IMG experiences in Canada for example, have examined the discrimination that happens in professional settings towards IMGs from Canadian trained doctors (Neiterman, Bourgeault, 2015). As with many other migrants, IMGs face host country discrimination, isolation, new cultural expectations and issues with housing and transportation (Chen, Curry, Bernheim, Berg, Gozu & Nunez-Smith, 2011). For IMGs with families, how a host country accepts migrants will have wider effects on how connected they feel to their new communities.

Cultural Awareness in IMG Orientation

The recognition of how culture affects health and wellbeing has been well established internationally. Focusing specifically on indigeneity and health the Seventy-sixth World Health Assembly saw a reiteration of earlier WHO resolutions from a number of members “Recalling that Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health, as declared by the United Nations Declaration on the Rights of Indigenous Peoples adopted by the United Nations General Assembly through resolution A/RES/61/295” (WHO, 2023). Improving the Social determinants of Health is a key goal in achieving the ‘highest attainable standard of physical and mental health’ but, how health providers address indigeneity, also has an effect on health outcomes.

A recent study concluded that a lack of orientation and cultural learning opportunities were barriers to positive acculturation (Mannes, Thornley & Wilkinson, 2023). It has been argued that dominant cultural contexts shape professional values in most countries (Vaughn, Jacquez & Bakar, 2009). As of 2023 the majority of IMGs vocationally registered in New Zealand have immigrated from the UK and Ireland (37%), Australia (10.5%) and South Africa (10%) (MCNZ, 2022). The two countries that provide the most IMGs to New Zealand have medical training and practice that is grounded in Western biomedical theory. This is unsurprising considering the rigorous registration process is based upon holding qualifications that are equivalent to New Zealand medical training. However, there is a significant gap in this equivalency regarding indigenous health care, with specific reference to Māori as bicultural partners. The scope of this review does not extend to an examination of the specific cultural contexts of these countries beyond the observation that they all have their own unique histories and social environments that shaped them. Additionally, while every IMG will be shaped by the system that produced them, their own individual lived realities are shaped by a diverse number of experiences. What is evident and pertinent is that most of these doctors would not have worked in rural New Zealand or with a Māori population before arriving. The next section will examine the orientation practices of Australia and Canada, with an emphasis on cultural orientation education.

The New Zealand Orientation Processes

The Medical Council of New Zealand (MCNZ) "is the statutory organisation responsible for protecting the health and safety of the public by ensuring doctors are competent and fit to practise medicine." (MCNZ, 2011). The expectations set out by the MCNZ (2011) for IMGs starting work in New Zealand is that competence is ensured by following the official 'Orientation Induction and Supervision for International Medical Graduates' handbook. This handbook suggests ways to prepare IMGs for New Zealand practice while also outlining the supervision process. Unlike Australia and Canada, the MCNZ does not require a compulsory examination for all IMGs registering to practice in the country. The guidelines are comparatively vague and rely on both the practice and the IMG ensuring compliance. The handbook explains that "there is no one way to orientate and induct new staff. Orientation and induction should be adapted to fit your organisation's culture, and the needs of the individual IMG" (MCNZ, 2011). The IMG is also encouraged to take control of their own orientation and induction process (MCNZ, 2011).

The primary resources at hand for IMGs and practices, are some practical ideas from the handbook itself, mentoring or buddying and *Cole's Medical Practice in New Zealand* (Morris, 2021), a book offering insight into New Zealand medical practice. The handbook offers practical suggestions such as giving the IMG a starter pack before they arrive in New Zealand; meeting them at the airport; organising a social occasion for them; and a gradual introduction to work after long international flights (MCNZ, 2011). The practice of shadowing a colleague while observing their practice is another suggestion aimed at orientating the new IMG. Mentoring by older more experienced doctors is suggested for young IMGs, while buddying is suggested for older more experienced IMGs.

At the time of writing this thesis there has been some significant changes to how cultural safety is operationalised within New Zealand medicine. A Cultural Safety Training Plan for Vocational Medicine in Aotearoa (Simmonds, Carter & Haggie, 2023) has been developed by Te Ohu Rata o Aotearoa, Māori Medical Practitioners Association (Te ORA) and Te Kaunihera o Ngā Kāreti Rata o Aotearoa, Council of Medical Colleges in New Zealand (CMC). These documents are supported by the MCNZ and emphasise the importance of cultural safety, while offering a plan to achieve culturally safe practice across New Zealand. There has also been a policy change that makes training related to cultural safety an ongoing requirement for medical registration. The Cultural Safety Training Plan for Vocational Medicine in Aotearoa (2023) is a document that could improve health outcomes for Māori. These are, however, part of ongoing professional development and don't apply to IMGs arriving in the country. There is, however, the potential for an improved level of cultural safety expertise held by New Zealand doctors leading to an improved level of supervision for IMGs.

New Zealand Medicine and Cultural Awareness

New Zealand medical organizations have moved away from solely using cultural competency training programs to educate doctors about minority cultures. Currently, the MCNZ promotes three strands of knowledge around culture: Cultural Competency; Hauora Māori; and Cultural Safety. Cultural competency education is the most common approach internationally for providing culturally appropriate care for diverse populations in training (Shepherd, 2019). According to Sue (2009 cited in Horvat, Horey, Romios, Kis-Rigo, 2014), "the components of cultural competence education for health professionals generally include cultural awareness,

cultural knowledge and cultural skills" (p. 7). Cultural Safety was developed in New Zealand by the Nursing Council of New Zealand through the work of Irihapti Ramsden, Māori nurses and nurse educators. The process was instigated due to concerns within nursing about health inequity for Māori such as higher rates in asthma deaths, rheumatic heart disease and cot deaths (Papps & Ramsden, 1996). Within the 'Cultural Safety Training Plan for Vocational Medicine in Aotearoa' the authors define cultural safety as transformative action (Simmonds, Carter & Haggie, 2023). This emphasis on medics taking responsibility for social change, is a contrast to most cultural competency training programmes that emphasis a more passive approach to social justice. The slightly overlapping cultural competency and cultural safety strands are complemented by Hauora Māori training that has occurred in New Zealand medical schools since the mid 1980's. There is an emphasis on Mātauranga Māori (Māori cultural knowledge) and Māori conceptualisations of health within the colonial context. Models of health are promoted such as Te Whare Tapa Whā, Meihana Model and the Hui process. This training emphasises the holistic nature of Māori worldviews while acknowledging the diversity of Māori beliefs. This New Zealand specific approach to providing culturally equitable through medical training, may contrast with the curricula studied by arriving IMGs. Currently, it appears that the time allotted to orientation and the structures that support orientation allow little time to adjust to this contrasting approach. This time pressure is exacerbated by the current (and historical) shortage of doctors in high demand areas of New Zealand. Without a defined pre training programme that could hypothetically orientate IMGs on Cultural Competency, Cultural Safety and Hauora Māori, the responsibility for orientation lies solely with the medical practice.

Chapter conclusion

In this chapter I have endeavoured to provide the historical, social, and cultural contexts that are involved in the development of Māori health across medical epistemologies, colonial public health policy and rurality. This setting provided a conceptual space from which the acculturation challenges, current practices and conceptualisations of culturally aware practice involving IMGs could be better understood.

Currently, biomedical practice is so pervasive globally that it has almost become synonymous with healthcare in Western countries (Valles, 2020). The assumption that biomedicine is the gold standard or in some way unimpeachable as an approach belies the cultural tradition inherent in this system of knowledge. The successes and utility of biomedicine are important to

acknowledge. However, the mechanistic, reductionist and ultimately colonising characteristics have often been a poor fit for indigenous peoples (Nelson, 2014). The biopsychosocial model has offered medicine an alternative approach in conceptualising health within a Western setting that incorporates a partially holistic way of locating health via the environmental influences around the individua (Engel, 1977). This model has influenced different medical fields over the last five decades but has faced criticism around its lack of applicability, nuance and dependence on current Western medical practices. The utilisation of the Social Determinants of Health to explain inequity in health outcomes has helped to shift the burden of ill health from individuals or cultures to macro influences within societies. For Indigenous peoples, the upstream affects created by colonializing practices such as dislocation from land or language can continue to perpetuate health inequities (Durie, 2004). Interacting with healthcare systems that continue to maintain colonizing practices through treatment approaches, is an ongoing issue for many indigenous peoples.

The struggle to maintain a continuity of cultural practices throughout the colonization of Aotearoa and repetitive assimilatory policies, has defined the Māori health experience (Durie, 1999). The assimilation of a culture that is predominantly collectivist and interconnected, into the individualistic and reductionist policies of New Zealand governments has done little to alleviate long standing health inequities. The Māori population has gone through massive population decline, has adapted to Western practices to stave off extinction and has struggled to exert control over our own health practices throughout the 20th century (Lange, 1999). The global awakening of Indigenous resistance in the 1970's helped to promote a Māori renaissance, that reshaped the health discourse towards demanding policies that catered for a Māori worldview (Pomare, et al., 1995). The subsequent decades have been defined by devolutionary policies by the New Zealand government towards Iwi providers, that have been undermined by consistent, fair or equitable funding practices. The Waitangi Tribunal's Health Services and Outcome Inquiry of 2019 has detailed several long-standing issues with Māori health provision over the last 20 years. Currently, the transition from District Health Boards to the new, centralised national health agency Te Whatu Ora is still in its infancy, making it difficult to draw conclusions around the future of Māori health policy.

An increasingly globalized medical workforce internationally, has increased the reliance on International Medical Graduates in OECD countries. IMGs make up 53.7% of the current

number of GPs working in rural New Zealand hospitals (MCNZ, 2022, p. 34). These doctors arrive from a variety of countries with different cultures and life experiences. The motivations for immigration vary across this workforce, as does the level of buy-in to rural communities and New Zealand medical culture. Like most immigrants the challenges of acculturating are ever present (Berry, 2006) and involve both the professional and social aspects of the IMGs lives. The current support in place for IMGs may vary significantly across different practices in New Zealand. Internationally the approaches to IMG cultural orientation illustrate a wide range of approaches that lean towards culturally competency centred skills-based assessments. Within the context of cultural orientation for IMGs beginning to practice in rural New Zealand communities, there are three main strands: Cultural competency, Cultural safety, and Hauora Māori. How and when these strands are taught or learned may depend on the quality of supervision in the individual practices (Jones, et al., 2010).

Culturally appropriate care that respects the cultural identity of the patient is vital to positive health interactions and by extension, outcomes. Within the literature there is a gap between understanding what rural Māori consumers might want IMGs to know before starting practice in our communities and what knowledge is being imparted on IMGs. In the next section I will discuss how a Kaupapa Māori approach to qualitative research offers an opportunity to understand the social, historical and cultural dynamics between rural Māori realities, health services and IMG experiences.

Chapter Two: Methodology

In this chapter, I will outline the methodological approach taken in my study. The chapter begins with an outlining of the process involved in selecting a site of research and how this journey informed my approach to the relationships between identity and reconnection. This section follows with a brief description of my whānau in Dargaville and how a generational cultural disconnection led to research in the Hokianga. The use of Kaupapa Māori research, autoethnography and case-based research is presented as having an epistemological coherence that aims to safeguard or promote my ethical concerns as a researcher. A Kaupapa Māori approach helped to redress the effects of historical narratives that have marginalised indigenous voices by positioning "researchers in such a way as to operationalise self-determination (agentic positioning and behaviour) for research participants" (Bishop, 1999, p. 1). As Māori, I have an obligation to ensure that these stories are not only given primacy but are used to help clarify Māori attitudes towards health provision. An autoethnographical approach integrated well with the Kaupapa Māori epistemology by using my experiences as a patient, as whānau member, as husband and step- son to a doctor, and as Māori to reflect on current theories around doctor-patient interactions for Māori. There is also space around these processes to reflect on my cultural identity and examine how being Māori is experienced by my informants. Case based research encourages the researcher to be accountable for their actions by acknowledging the role that we play when conducting research (Hodgetts & Stolte, 2012). As privileged insiders we have a responsibility to our informants that continues beyond the timeframe of the research. The accountability inherent in all these methodological approaches strive towards limiting potential harm for my participants and whānau. It was important to select a location for research that framed my own experience by being historically, socially, and culturally relevant to me.

Site of Research

Identifying a location from which to draw participants from was an important process in investigating and developing ideas around Māori patient interactions, International Medical Graduates (IMG), and rural communities (Elwood & Martin, 2000). In utilizing both Kaupapa Māori and autoethnographic approaches, the criteria for selecting a community had to encompass places of historical relevance to me as Māori (Whitinui, 2014). The location needed to host the convergence or overlap of my lived reality, the experience of my participants as

Māori, interacting with a rural health service and the IMG doctors who treat them. Settling on a site of research proved more complicated than was expected but the journey proved illuminating regarding identity, whakapapa and reconnection (Stevenson, 2018).

Whitinui (2013) suggests that indigenous researchers should look to locate 'self' as an insight into the interactions that form collective identity and that the "…benefit of (re)engaging in cultural sites or scared spaces has enabled indigenous peoples to rewrite their history and to reclaim an indigenous world view…" (p. 476). My mother grew up in Dargaville (Takiwira), which is a town located near the west coast of Tai Tokerau/ Northland near the top of Aotearoa New Zealand's North Island. The interconnection between the *whenua* (land) and who we are, is a vital part of the Māori worldview (Smith, 2015). For me, selecting a location of research was a difficult decision that involved factors both in and out of my control. A combination of issues around my self-identity as Māori, the disconnection of my whānau to our mana whenua and the necessity of building relationships through face-to-face interaction, posed several challenges. In many ways my family's attitude to health and tikanga reflects the disconnection that has occurred for many Māori through the process of colonization (Walker, Eketone & Gibbs, 2006). My Poppa lived through a period of marginalisation where the expressions of Māori ways of being, the connections with Ōtūrei marae and te reo Māori were discouraged. The relationship between tikanga Māori with my mother and her siblings reflects this disconnection. While there are still ties to the local Māori community, it occurs in ways that reproduce the assimilatory environments of the mid-20th century (King, 2019). This disconnection made following a Kaupapa research approach difficult in Dargaville, leading to my own journey of reconnection back to the traditional turangawaewae of my tūpuna (ancestors) in the Hokianga.

The Hokianga is a region based around the Hokianga harbour on the West coast of Tai Tokerau/ Northland. It is represented by a convergence of three Iwi: Ngāpuhi, Te Rarawa and Te Roroa. The settlements around the harbour are small, with a low socio-economic population, and isolated from urban centres. Rawene is the largest town and the home of Hauora Hokianga (Hokianga Health), the health provider for the region. Rawene eventually became the primary site of research due to whakapapa, whānau, and the unique features of the health organisations. As previously stated, my whakapapa leads back to the Hokianga and whanaungatanga (making connections) has been developed between my whānau in Dargaville and relations in Rawene. My stepfather worked as a locum in Rawene Hospital, had participated

in a pōwhiri and had made connections with the staff at the hospital. Through these connections, I realised that Hauora Hokianga was a location that offered a dynamic environment where Iwi and the health organisation were working together to educate a considerable number of IMGs on the relationship between local tikanga and health practice.

In response to this change in location came a change in my overall approach to this project. Hodgetts (2000) discussed the need to shape approaches to the purposes of the study. The initial intention had been to spend time with whānau in everyday interactions was structured to "explore what the world means for human life through everyday living…" (Hojholt & Schraube, 2015, pp. 2-3) to understand what Māori consumers wanted from IMG orientation programmes. As this potential whānau-of-interest became harder to develop, I began to look more specifically at how Iwi and health organisations interacted with IMGs to shape their knowledge of Māori health interactions.

Hauora Hokianga was one of New Zealand's first regional trusts to run its own health services. This occurred due to the neoliberal economic policies of the late 1980's and 1990's where services in rural regions were facing cuts that affected the wellbeing of Māori (Smith, 2007). These effects were two-fold. Firstly, the hospital and its services were an important element of the fabric of the community. Here the institution can be used to describe the importance of place as "as an interactive relationship between the experience of a tangible place and a person's place-in-the-world." (Kearns & Joseph, 1997, p. 24). The hospital in this sense acted as a symbol from which social identities can be formed (Kearnes and Joseph, 1997). Secondly, the restructuring of rural hospitals had an outsized effect on Māori or those from lower socio-economic backgrounds (Kearnes & Joseph, 1997). This negative relationship can be attributed to the 'inverse care law', where those who most need health services receive less care (Hart, 1971; Kearnes & Joseph, 1997). The Hokianga has a significant Māori population (63.1% Hokianga South; 86% Hokianga North) and as many as 96% of the population considered high needs (Hauora Hokianga, 2023). For the Hokianga, it meant an increase in the transport costs involved in driving to Whangārei Base Hospital and the degradation of an institution that was a source of community pride. The community faced being stripped economically and socially of a symbol that was integral to their collective identity (Kearns, 1991).

In its current iteration, Hauora Hokianga meets the criteria as a Māori health provider and is governed by a trust that is represented by residents of the 10 clinic areas (2 trustees each) and local Iwi (4 trustees). There must be 50% Māori representation on the health board at any time (Hauora Hokianga, 2021). There are strong links currently between Hauora Hokianga and local Iwi that is evident in a number of health initiatives aimed at addressing inequitable health outcomes for local Māori. One of these initiatives, Te Takapau Wānanga, utilises local tikanga to educate kaimahi (staff), medical students and new IMGs on cultural awareness using a programme called Takapau Taonga. The organisation relies heavily on IMGs, so having an international workforce that was interacting with a proportionately high Māori community while receiving cultural awareness training provided an opportune environment for my research project. The suitability of the location to the research aims combined with links to the community was progressed through whakawhanaungatanga, a process of "…identifying, maintaining, or forming past, present, and future relationships…" (Walker et. al., 2006, p. 334), that located me in the community.

Kaupapa Māori

The relationship between rural health policy in Aotearoa New Zealand and the effects of the 'inverse care law' on local Māori, are a key focus of my research. Focusing on the Hokianga as a location that I am invested in, helped to illustrate the complexity involved with the provision of health care for rural Māori. It was not enough however, to describe the interaction of policy, doctor-patient dynamics and patient satisfaction via the same traditional paradigm that has maintained the ongoing inequality in health outcomes. This section will lay out why a Kaupapa Māori approach was the most appropriate theory to address Māori attitudes towards cultural safety in medical consultations.

My work drew on several Kaupapa Māori scholars (Smith, 2015; Smith, 2012; Pihama, 2010; Rollerston, Cassim & Kidd, 2020) to ensure that my research was faithful to overall Kaupapa Māori aims. Realising my motivations for research and formalising them, provided a touchstone that aided me in conducting field research that stayed true to these research aims. Linda Tuhiwai Smith's (2015) work on developing motivations for research were utilised throughout. These included questions about what research was being carried out, who it was for and whether it would be transformative. These questions also focus on who would benefit, own, and judge the worthiness of the research (Smith, 2015). In this sense, an acknowledgment of

the stake holders involved and the power dynamics inherent in our relationships was critical. As someone who is married to a doctor and who is in a generally privileged position in doctor-patient interactions, it was important that the themes originated with the lived experience of Māori patients and developed from there.

Kaupapa Māori theory is an indigenous framework that promotes research that places Māori welfare at its core. Pihama, Cram and Walker (2002) describe Kaupapa Māori as becoming "… an influential, coherent philosophy and practice for Māori conscientization, resistance, and transformative praxis" (p.33). The principals that underlie Kaupapa Māori research were developed in concert with a worldwide movement for self-determination by indigenous and marginalized peoples (Bishop, 1999; Pihama, 2010). Curtis (2016) posits that Graham Hinengaro Smith's formalisation of Kaupapa Māori as research theory, moved the term from intrinsic to explicit. This inherent difference creates a position whereby Māori can "have theories of the world both inside and outside of Māori culture" (Curtis, 2015, p. 400).

While acknowledging the diversity of Māori realities (Durie, 1994), Kaupapa Māori places identifying as Māori at the centre of the approach (Pihama, Cram & Walker, 2002). This is achieved by positioning *Te Ao Māori* (Māori worldview) as the paradigm from which all research decisions are made. Te Ao Māori, the broad Māori worldview, promotes an interconnected and holistic reality where all things living and non-living share interrelationships (Durie, 1985). Henry and Pene (2001) argue that "…Kaupapa Māori is both a set of philosophical beliefs and a set of social practices (*tikanga*)" (p. 237). For Māori, there is a holistic worldview where all things are interconnected; whānau, ancestors, and the land. This tangle of relationships reflects a cosmology that is specific to Māori (Rua, Hodgetts & Stolte, 2017). This worldview is not reflected in the prevailing Western scientific paradigm that is informed by Cartesian dualism (King, 2019). The separation of the body and the mind into component parts, leads to the isolating of all social, cognitive, and physical mechanisms from their wider context. The building of theory and thought on Māori cosmologies helps to clarify what constitutes reality from our perspective (Bishop, 1999). This approach challenges the often-unacknowledged positivist assumptions inherent in Western biomedical research (Lyons & Chamberlain, 2006).

The application of Kaupapa Māori theory in health is a recognition that we are dealing with an indigenous culture that has been dominated by Western conceptualisations of health and

wellbeing (Eketone & Walker, 2015). By discussing overall Māori *hauora* (wellbeing), I can address the importance of different conceptualisations of indigenous health and investigate how this worldview is interacting with Western medical models in Aotearoa New Zealand. My research was motivated by a desire to build on inherent strengths within Māori communities rather than over emphasise Māori health disparities. Prominent Kaupapa Māori researchers have sought to challenge western models of knowing and knowledge-construction (Henry & Pene, 2001). Rejecting cultural deficit theories that are maintained through inferential health statistics was a key component of this approach. These statistics have the effect of equivalating and framing indigenous wellbeing in terms of Western conceptualisations of poor physical health (Fogarty, Bulloch, McDonnell & Davis, 2018). They also help to reinforce stereotypes about Māori and poor lifestyle choices. Taken to its natural conclusion within a Western paradigm, the association of Māori and poor health outcomes with individual responsibility leads to a culture of victim blaming. The emphasis on health statistics circumnavigates the historical, social and cultural worlds that all health behaviours occur within.

Building a tacit relational commitment (Bishop, 1996) was a primary goal for my research. Embracing whakawhanaungatanga (building relationships) as a key component of my research approach was implemented to ensure that concerns about the locus of power were addressed. Whakawhanaungatanga is the building of ties between groups that are developed through shared experiences, such as working together. However, my requirements as a researcher needed to be secondary to the needs of the community. This is not necessarily always an easy balance to achieve. With all the good intentions of the seeker considered, the community of the marae or town, have their own lived realities. They are not a monolithic entity that exists to help individuals find themselves spiritually. The building of relationships needed to occur in a way that would impose the least on a community while trying to undertake research that enriched a population that is coping with their own external challenges. Part of this process however involved engaging with kaumatua about the appropriateness of my research and whether my approach was tika (correct). As someone who has whakapapa ties to the rohe (tribal territory), but is not a ‘local’, it was important to find members of local Iwi who had the mana (authority) to understand the unique interaction of tikanga and the needs of stakeholders (Smith, 2015).

Successful Kaupapa Māori research needs to be relevant to Māori communities and the researcher(s) need to be accountable for the research process (Jones, Ingham, Davies and Cram, 2010). It was important to place the potential benefits for the community, as a primary priority of my research outcomes. Not all research is undertaken with altruistic purposes in mind and beneficence needed to be a motivating factor in my overall approach. For a community or culture where exploitation has been historically commonplace, there should be an emphasis on identifying the benefits of the research for them. Finding the most appropriate 'hauora pathway' (Jones, Ingham, Davies & Cram, 2010) needed to be directed by my community. Presuming what social issues were relevant to the community from my position as researcher, would have only reproduced the top-down approaches of centralized health policies.

Avoiding the reproduction of health research that exploits marginalised communities meant acknowledging my place as a subject with opinions, biases, and an interest in the outcomes of the study (Nicholls, 2013). My lived experience as Māori, researcher and husband of an IMG doctor provided a privileged position from which to gain insights into the interaction between cultural awareness, the needs of rural Māori and the acculturation of IMGs. This potential strength however needed to be wedded to a research methodology that fitted with Kaupapa Māori research aims and offered a level of accountability. In the next section I will address using an autoethnographic approach to privilege Māori worldviews, while acknowledging the important role that IMGs play in Hauora Hokianga (Whitinui, 2013).

Autoethnography

Bochner and Ellis (2016) have described autoethnography as a 'genus' that encompasses a wide variety of first-person research and is utilised by many different disciplines, such as in psychology. However, for marginalised populations, positivist epistemologies have done little more than reinforce historical power imbalances within society (Tiakiwai, 2011). Autoethnography offers a set of counterhegemonic tools that can be used to empower the voiceless (Martin Boro, 1994). The use of my subjective experience as an insider, to gain a deeper understanding of how cultural safety is experienced in consultations, acted as a filter from which the political elements of health interactions were examined. This section will highlight the use of epiphany as a tool for locating beneficent research; will explain the suitability of autoethnography alongside Kaupapa Māori theory; and explain the importance of context via emic approaches with an emphasis on *kanohi ki te kanohi*.

In contrast to the participant-observer approach of ethnography, autoethnographers utilise epiphanies drawn from lived experiences (Ellis, Adams & Bochner, 2011). The aim being to, "… use personal experience to illustrate facets of cultural experience, and, in so doing, make characteristics of a culture familiar for insiders and outsiders" (Ellis, Adams & Bochner, 2011, p. 275). Drawing on lived experience in this way allowed me to use my experience as Māori, husband to an IMG, patient and researcher to locate an area in the health system that I viewed as a barrier to improving indigenous health outcomes. The use of lived experience and subsequent reflection, helped me to identify a practical issue where investigation could encourage beneficent solutions. For example, the closest approximation that I have to an 'epiphany' (Ellis & Adams, 2014) would be from the result of a conversation that I had with a family member after a cultural competency teaching session at her work. They are a specialist in a New Zealand regional hospital and the teaching session was centred around developing staff awareness about the ongoing effects of colonisation. The coordinator expressed these ideas forcefully in a way that perhaps underlined his passion for the subject, but also hinted at his exasperation after meeting repeated resistance to his main points. As the lesson progressed more and more staff members got their 'backs up' and viewed the content as a personal attack. Some staff members left the lesson affronted. I realised that I had been lulled into the false idea that the destructive consequences of colonisation were both well-known and widely believed. It became a catalyst for wider questions about how well-prepared doctors were for working within Māori communities and what support was in place regarding cultural awareness education for Internationally trained doctors.

This insight into cultural awareness in New Zealand health education programmes potentially raised questions around historical grievances that were at the core of historical race relations. The research topic needed to be allied to an approach that embraced the contextuality of these dynamic interactions while promoting equitable rural Māori health outcomes (Reid, Taylor-Moore & Varona, 2014). When analysing the relationships between IMGs, rural Māori patients, and health organisations the lived reality of all the stakeholders needed to be respected. An insider perspective allowed me to ensure that the unique contexts of the participants were approached in a non-judgmental way that upheld the mana of all parties (Royal, 2009). I was able to draw upon friends and whānau who were either tauiwi or IMG doctors, or leaders within our local Māori communities for help in maintaining these participant relationships.

Autoethnography is an approach that intertwines well with a Kaupapa Māori research framework. Whitinui (2014) regards autoethnography "as a culturally informed research practice that is not only explicit to Māori ways of knowing but can be readily validated and legitimated as an authentic 'Native' method of inquiry" (p. 456). Some indigenous researchers have viewed autoethnography as a methodology that allows them to work outside of colonizing discourses (Whitinui, 2014; Dutta, 2017; Chawla & Atay, 2018). The creation of this space has allowed researchers of marginalised cultures such as indigenous peoples, LGBQT, trans rights and disability rights, to promote minority perspectives. Ellis and Bochner (2011) underline the counter-hegemonic power of autoethnography:

> *Furthermore, there was an increasing need to resist colonialist, sterile research impulses of authoritatively entering a culture, exploiting cultural members, and then recklessly leaving to write about the culture for monetary and/or professional gain, while disregarding relational ties to cultural member. (p. 274)*

As was explained in the previous chapter, the history of indigenous health policy in New Zealand is heavily influenced by colonisation, which extends to research that has been enacted upon Māori rather than for or by us (Bishop, 1999). Regarding this research project, the use of autoethnography aided in focussing on empowerment through relationality rather than judgement through false notions of impartiality (Smith, 1992). Indigenous psychologists look to challenge the ongoing application of decontextualised, Eurocentric knowledge on native peoples (Sonn, Rua & Quayle, 2019).

The ability to (re)connect and (re)engage with my community was central to coming to know my identity and provided access into the dynamic lived realities of my participants (Whitinui, 2014). (Re)connecting with whanau and IMGs in Rawene involved two main processes. The first was physically reintroducing myself after years away from the town. The necessity of committing to kanohi-ki-te-kanohi (face to face communication) was a challenge in the context of the outbreak of Covid-19 in Northland. Whitinui (2010) describes kanohi-ki-te-kanohi as "…a culturally preferred and legitimate means of communicating, engaging, and interacting with indigenous peoples on their terms" (p.458). The importance of 'he kanohi kitea' to my approach was that it allowed "…the people in the community to use all their senses as complementary sources of information for assessing and evaluating the advantages and disadvantages of becoming involved" (Pipi, Cram, Hawke, Hawke, Huriwai, Mataki, Milne, Morgan, Tuhaka & Tuuta 2004. p. 146).

The next section will address the use of case based research and how the insider positioning of an autoethnographic approach, allows for the opportunity to collect descriptive data that "…allow us to investigate a particular social event, situation, or condition, and to provide insights into the underlying processes that explain how the particular event or situation came to be" (Small, 2009; Swanborn, 2010, cited in Hodgetts & Stolte, 2012).

Case Based Research

The choice of case-based research helped to facilitate Kaupapa Māori and autoethnographical approaches while promoting my "motivation to illuminate understanding of complex phenomena" (Harrison, Birks, Franklin & Mills, 2017, p. 5). The socio-cultural dynamics at play in the interactions between the different stakeholders involved in rural Māori health and cultural awareness programmes are complex. After a wide range of informal conversations with key informants in rural settings, I decided to concentrate on developing cases around the IMGs who worked at Hauora Hokianga and members of the local Iwi who were driving Hauora Māori within the organisation. The focus on these participants helped to "…exemplify key points of concern, ground societal process in concrete events, and foreground stakeholder experiences" (Hodgetts & Stolte, 2012, p.179). The dynamism inherent in social interactions needed an approach that was responsive to complexity, contextuality and experientiality (Mabry, 2008). Having participants who understood the nuances of local tikanga, the history of health services in the Hokianga and had an inherent understanding of how local iwi experience health, helped to explain some of these ambiguities while still providing a patterned context of the topic. Additionally, capturing the complexity of the experiences of IMGs through the environments that shaped acculturation and their attitudes to healthcare, needed a flexible format that allowed for (and encouraged) wide ranging discussions.

While following an interpretivist methodology that looked for interesting areas of investigation as they arose, I also needed an approach that was both flexible and responsive to these factors. Māori health provision, and the lived reality for Māori living in the Hokianga is varied and complex. As Hodgetts and Stolte (2012) state, "human existence, particularly in communities under pressure is contradictory, complex and full of ambiguities" (p. 382). This dynamism in health experiences meant that research tools needed to be robust, responsive, and reflexive (Finlay, 2002). During face-to-face interactions or over the phone, I was able to firstly develop relationships and then learn details that provided invaluable contextual information.

Case based research is also a pragmatic approach to research that contains the flexibility to embrace different paradigms (Harrison, Birks, Franklin & Mills, 2017). Both qualitative and quantitative researchers have utilised case studies effectively within health research (Edwards, Dattilio & Bromley, 2004). Case based research offers what has been viewed as a 'bridge across paradigms' in terms of its application to both qualitative and quantitative research designs (Mabry, 2008). The focus in my research, however, was for an emphasis on depth rather than breadth. Broadly speaking, the quantifying of Māori dissatisfaction with healthcare has been captured effectively, while the reasons for these attitudes have not been addressed as thoroughly. Part of capturing this underlying rational depends on hearing the stories of those affected. Case studies that emphasis a narrative approach to knowledge creation, often aim to develop "the provision of sufficient detail so to illustrate the unique features of a case" (Stake, 1995 cited in Hodgetts and Stolte, 2012, p. 382). These "thick descriptions" of social phenomena provided an opportunity to develop a deeper understanding or awareness of our attitudes towards cultural safety and healthcare interactions. As Holloway (1997) states: "Thick description builds up a clear picture of the individuals and groups in the context of their culture and the setting in which they live" (cited in Ponterotto, 2006, p. 540). These descriptions allow for a holistic analysis of gained knowledge that fits well with Māori concepts of hauora and the culturally patterned interactions of participants.

Case based research fitted naturally with both autoethnography and Kaupapa Māori research practices. All these approaches are action orientated and involve close participation with subjects. The application of praxis (action) to social research helps to promote community empowerment. However, praxis without thought or planning can lead to research that wonders away from research aims. Flyvbjerg (2004), describes the process of phronesis as:

> *…that intellectual activity most relevant to praxis. It focuses on what is variable, on that which cannot be encapsulated by universal rules, on specific cases. Phronesis requires an interaction between the general and the concrete; it requires consideration, judgement, and choice. More than anything else, phronesis requires experience. (p. 288)*

The interplay between experience, experiencing and learning, helps the researcher to explore how the specific, links with wider macro trends (Hodgetts & Stolte, 2012).

Case studies are appropriate for social research because it is an approach that embraces the importance of practical experience (Flyvbjerg, 2006). It is important that "The choice of method should clearly depend on the problem under study and its circumstances" (Flyvbjerg, 2006, p. 10). The understanding of dynamic social interaction cannot be captured purely by theory. As Flyvbjerg (2006) states: "This is the limitation of analytical rationality: It is inadequate for the best results in the exercise of a profession, as student, researcher, or practitioner" (p. 5). Most experts are not born from textbooks, but from applying practical application to the relative problem. This context-dependent knowledge is best attained via methods that encourage social interaction, such as *kanohi ki te kanohi* (face to face interactions) (Walker, Eketone & Gibbs, 2006).

The development of new conceptual frameworks through case studies is important to both questioning the status quo and offering insights into potential action. Within marginalised communities, the status quo is often supported by conceptual frameworks that reinforce that marginalisation (Bishop, 2011). By building cases that can form "biographies of illness" (Hodgetts and Stolte, 2012), new ways of thinking can be enacted within real life situations. This was an important consideration in terms of advancing my Kaupapa Māori research aims of championing transformative ways of thinking that benefit us as Māori (Smith, 2012). The final section of this chapter will lay out the methods used in the gathering of data for this thesis. I will explain the cultural context from which the participants were selected, before discussing the participants themselves and conclude with a description of the analysis used to understand the themes that arose from the semi-structured interviews.

The Research Process

McKenna and Main (2013), view understanding communities and their priorities as a key aspect of community research that empowers, rather than focuses on, deficit-based perspectives. Using insider positioning to confirm, reaffirm or rethink these research priorities helped to shape participant involvement. Initial discussions were conducted over a cup of coffee or tea with members of my whānau or people closely aligned with my whānau in Dargaville. These interactions were culturally patterned and informed in ways that represented "…the enactment of culturally informed everyday social practices" (King, 2019). Discussions about research would be preceded by greetings, discussions about whānau, general wellbeing and wider topics. Displaying manaakitanga in the forms of koha (such as eggs from my chickens) or receiving

morning tea from my hosts were part of these culturally informed everyday practices (King, Hodgetts, Rua & Morgan, 2018).

Being able to discuss how health was experienced in Dargaville with kaumatua and other members of the community, helped me to frame my research. Key informants acted to move the focus of the research from the purely theoretical to the "problem and action orientated" (McKenna & Main, 2013). Being able to experience the day-to-day challenges involved in health provision with these key informants, also helped in providing contextual details. At the same time, there was also an opportunity to have informal discussions with doctors, both international and local about the challenges of providing health provision. The pressure to provide health services in an understaffed working environment was a topic that arose consistently and helped in illustrating the day-to-day challenges of working as a GP in rural Tai Tokerau/Northland.

The flexibility of the overall qualitative research approach was utilised to link theory with practice through reflexivity (Watt, 2007). Whilst the location of my research moved away from Dargaville, the informal conversations that I had as part of a community, were invaluable in providing material to reflect upon. I was able, using reflective journaling, to crystalise the direction of the research project and streamline my approach to the topic (Ortlipp, 2008). These reflections changed the direction of the research from being mono-directional to something that was more inclusive and geared towards collaboration. The original focus had been on whether IMGs were meeting the needs of rural Māori, but through discussions and reflection, it became evident that both sides of the interaction needed to be accounted for so that the dynamic, contextualised interactions of the stakeholders could be better understood. While Iwi participation and experiences remained at the core of the research, the journeys of IMGs, from their initial training through to acculturation and practice, became an important voice in the research. This adjustment in focus reflected the collaborative component of all doctor-patient relationships and acknowledged that these interactions have two sides: "the patient's opinion about the doctor, and the patient's perception of the doctor's opinion about them, which may be reciprocal" (Ridd, Shaw, Lewis & Salisbury, 2008, p. 123). The overall thrust of the research became centred around how these stakeholders, from often disparate cultural backgrounds, felt that orientation programmes were preparing IMGs for culturally aware consultations.

The change in the direction of the research led to the need for a location that reflected a dynamic relationship between Iwi, IMGs and health organisation. The ability of interview spaces to shape research questions and offer insights into the microgeographies of communities underline the importance of location in qualitative research (Elwood & Martin, 2000). Conversations with whānau and key informants encouraged me to reach out to whanau in the Hokianga as a new site of research After initial discussions and grasping how the Hokianga Health Trust worked, I decided to approach IMGs at Rawene Hospital and the Pou Kara Ariki Marae to find participants.

Participants

Seven people were officially interviewed for this study, with a further five people involved who helped to guide and inform the research without being formally interviewed. Of these participants, two IMGs practiced outside of the Hokianga in other towns in Tai Tokerau/Northland. Their contributions clarified the lack of uniformity across different health organisations and highlighted the differences in Iwi participation. The main focus of the research however, ended up being on Hauora Hokianga. This group of participants were divided between IMGs and members of Te Takapau Wānanga who were all members of the Hauora Hokianga workforce. As with many health providers in the region, Hauora Hokianga is under pressure to provide the necessary services to the rohe. Medical staff and administrators are often working long hours to cover staffing shortages across the hospital. With this environment in mind, I decided to ask the Hauora Hokianga Medical Director whether GPs would be interested in talking to me and whether they (as an organisation), would be happy with me conducting my research in and around the community. I was able, in part, to draw on my stepfather's relationships with hospital staff as a way of developing whanaungatanga with the medical team (O'Carroll, 2013). The sharing of details about his time there, who he knew and how they were helped to pave the way for my own participant interactions.

Relationships were built in part through emails, phone calls and Facebook, but it was also important to conduct the interviews with IMGs face to face. The interviews with the IMGs were held either at the Boatshed café in Rawene or at Rawene Hospital in the consultation rooms. These locations were the choice of the IMGs and offered privacy, but also insight into their day-to-day lives. Face-to-face interviews were essential to the research because the geographical locations of our discussions added a "rich source of data about the social geographies of the

research situation and enable researchers to enrich their understandings of explanations offered by participants" (Elwood & Martin, 2000, p. 652). For example, sitting in a café on the wharf at Rawene while discussing the relaxed lifestyle of the Hokianga, but also the isolation, added contextuality to my understanding of the data. The interviews lasted from two-four hours and were semi-structured. Semi-structured interviews allowed me the opportunity to hear the narratives of these individual's lives to understand their motivations, challenges and aims for working in the Hokianga. This technique fit well with my overall inductive approach to analysis (Dew, 2007). The breath of this approach gave me a wider appreciation of the barriers and protective elements involved in healthy acculturation into rural Northland communities.

The interviews were recorded on my phone the Voice Memo app, after receiving verbal permission from all the participants. After recording, the interviews were transcribed by me and checked over two-three times for accuracy. In total I transcribed 16 hours of interview recordings. My IMG participants were from either Canada, USA, England or Spain. They all came from different backgrounds, family environments and were at different stages of their careers. Most of the participants had worked in other practices in New Zealand and had gone through the New Zealand Locums Orientation programme in Wellington. While one of the participants had arrived recently, others had been working in the Hokianga for four-eight years. I used pseudonyms to protect the privacy of the participants. As part of the overall ethical considerations of the research I have decided to not detail the backgrounds of my participants outside of pertinent details in the analysis section. This is due to the small population size of the region and the protection of participant privacy.

After talking to members of the community, the local Iwi participants ended up being two key informants that work for Hauora Hokianga and who facilitate the Te Takapau Wānanga course. Connection was suggested and made by a member of my whānau in Rawene who worked at the hospital and has many connections across the Hokianga. Through this cousin I was able to get in contact with a kaumatua at Hauora Hokianga. What began as a conversation about tapu and research in the rohe over emails, became a discussion about the history, present and future of Ngāpuhi, Te Rarawa and Te Roroa health in the Hokianga in person. As with the medics of the hospital, the members of the Hauora Māori team in Rawene were very busy due to the number of initiatives that are run from the Pou Kara Ariki Marae, the marae attached to Rawene

Hospital. This led to a shorter, more intense timeframe, as I was weary of placing a burden on the roopu.

The need for a tighter emphasis on the research question, led the focus away from a broader consumer opinions about health, towards in-depth conversations with key stakeholders. This was principally due to timing, as the Te Takapau Wānanga and Takapau Taonga programmes had recently been implemented and a great deal of transformation was occurring in the organisation, that specifically involved the relationships between local Iwi and IMGs. The specificity of this movement and its applicability to my research questions, narrowed my interview topics down to the development of this new approach and the reasons behind it.

I meet the kaumatua and his assistant at the Pou Kara Ariki Marae in Rawene. This marae is located underneath the main building at Rawene Hospital and is open to the public and hospital staff. It is a hub for hauora Māori and uses the space as an area for traditional practices like pōwhiri, as clinic for rongoā practice and as a base from which to coordinate with other marae in the Hokianga. The marae opens out onto gardens that contain a walk through a number of plants that are used for rongoā rakau (traditional medicines). As a token of my gratitude for the manaaki that was extended to me, I brought along three ngutukāka plants as koha to add to the replanting effort at the hospital. I was offered a biscuit and tea as we chatted about life. The interviews took three-four hours, and I walked through the gardens.

Analysis

The analysis for this thesis built on the epistemological foundations of Kaupapa Māori research theory by following a thematic interpretation that allowed for an examination of structural issues and socio-cultural contexts (Eketone, 2008). Inductive thematic analysis is a commonly used method in qualitative Kaupapa Māori studies and was viewed as a compatible approach with the overall research aims (Haitana, Pitama, Cormack, Clarke & Lacy, 2020). The seminal work of Braun and Clarke (2006) was utilised to help plan and complete my analysis. The choice of thematic analysis was made to encourage flexibility across a complex topic that involved socio-political dynamics across different cultural worldviews.

The corpus was transcribed by me orthographically, the night or day after the interviews. As someone with beginner/intermediate te reo Māori, particular attention was given to Māori phrases to ensure accuracy. The process of rechecking phrases (both English and Māori) was an important stage in the development of codes and themes. As the transcripts were being created, via multiple playbacks of the interviews, I was able to gain insights into vocal intonation and make notes that formed my initial impressions of the corpus (Braun & Clarke, 2006). These impressions informed initial reflections on the topic and ideas for coding were created in part from this process. With a great deal of data to analyse, it was imperative that initial impressions were made as an entry point to analysis.

The development of the analysis from the first interview to thematic mapping, was a recursive process where themes were reconstituted as understandings of the topic changed (Braun & Clarke, 2006; Kiger & Varpio, 2020). These ideas would occur on the drive back to Whangārei from Rawene, during transcription of during supervision meetings. This back-and-forth approach to code or theme creation was particularly relevant due to the breadth and complexity of the worldviews across stakeholders. The questioning of initial assumptions led to early ideas being transformed, reinterpreted, or discarded (Braun & Clarke, 2019). Reflexive journalling continued to aid in recognising the initial emergence of themes that in turn informed future research decisions, including further interviews (Braun & Clark, 2022). This flexibility was essential in understanding the dynamic interactions involved in IMG cultural orientation.

After transcription and a thorough reread of the corpus, coding was initiated using the highlighter function on Microsoft Word and a key (Blair, 2015). Where the data items had originated from in the corpus, was noted to ensure that the context of that item remained relevant to the analysis. Occasionally coded items might be duplicated in two different theme tables, but were differentiated through a letter assignations (a, b, c etc) (Braun & Clark, 2006). The creation of this data set allowed me to produce tables of the coded data that were then arranged into themes. These groupings of coded data extracts were placed on individual pieces of card and physically manipulated around larger theme boards. Patterns of meaning were uncovered that utilised past reflections and built on newly observed connections. Occasionally, this manipulation would lead to a new theme, created from coded data that sat outside of the established patterns. Once the themes and sub themes were organised into a thematic map,

the overall interaction between and within the themes were assessed for internal homogeneity and external heterogeneity (Braun & Clark, 2006).

Accessing the thematic map for external heterogeneity developed the themes into an overarching narrative, that was relevant to the epistemological positioning of the research (Braun & Clark, 2006). The thematic subgroupings were linked to relevant theories that were often informed by Kaupapa Māori or Cultural Psychology. For example, the 'story' created from the themes had to promote Kaupapa Māori initiatives that "develop intervention and transformation at the level of both institution and mode" (Pihama, Cram & Walker, 2002, p. 33). Dealing with two disparate cohorts lead to an initial split in the analysis between IMGs and Iwi participants. This was based on an early post-interview reflection that emphasised the differences in life experiences across groups, in conjunction with the similarities in their collective hopes for the community. The organisation was conceptualised to look at two different worldviews initially and then endeavour to work towards a theme that concentrated on culturally appropriate interactions and by extension practical solutions. In the following findings chapter, these themes of orientation, acculturation and the inherent strengths of rural Māori communities, are presented over two analysis sections.

Ethical Considerations

Ethical approval for this research was granted by the Human Ethics Chairs' Committee, School of Psychology, at Massey University (see Appendix A). The safety of the participants was assured through adherence to the Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants, Revised Edition (Massey Human Ethics Committee, 2017). This document was used to guide all participant interactions including the research approach, field work, data handling and analysis. As the research also involved Māori participants, Kaupapa Māori research principles were also used in conjunction with the Code of Ethics. The research principals put forward by Linda Tuhiwai-Smith (2015) helped to maintain the mana of the participants by offering practical Kaupapa Māori guidelines and reflexive questions.

In keeping with Kaupapa Māori principals and Te Ara Tika (Massey Human Ethics Committee, 2017) the research relied on Kaumatua (Iwi leadership) to make sure that research approaches

were tika (correct) and pono (honest) (Paki, 2007). The research design followed these directives and was planned in a way that reinforced connection and responsibility through whakapapa and whānau. The goals of the research aimed to empower rural Māori communities and promote tino Rangatiratanga (sovereignty). Whakawhanaungatanga was used to build and maintain the correct connections amongst the community and manaakitanga was displayed as a central practice in participant interactions (Bishop, 1999).

Whilst all ethical principles were acknowledged throughout the research process, there was a particular emphasis on maintaining autonomy, avoiding participant harm and ensuring that justice was at the forefront of participant interactions. This was particularly relevant to IMG interactions where the small size of the health organisations and the broad, personal nature of the discussions needed to be carefully considered regarding limiting harm. This privacy was ensured through the use of pseudonyms and limiting the personal information presented in the analysis.

There were a number of processes in place to minimise the risk of harm throughout the research. All participants were given verbal invitations and were communicated with via email prior to the interviews. Discussions about the nature of the research, and expectations were also discussed prior to recordings. Participation in the study was voluntary and participants were given the option to opt out of the process at any time. The raw data of the interviews was only available to me, as the sole researcher. Data was kept on my computer, under password protections.

Chapter Three: The IMG Experience

Biomedical competence forms the basis of international medical equivalency across OECD countries and remains the intellectual currency which International Medical Graduates can use to access employment across the developed world (Giuliani, Martimianakis, Broadhurst, Papadakos, Fazelzad, Driessen & Frambach, 2021). As covered in Chapter One, the way that biomedicine is expressed through different cultural contexts leads to a broad range of expectations and experiences across different countries training schemes. The variation in training approaches and the effect of the wider cultural environment increases the potential for acculturation stress for doctors undertaking medical migration. In the next section these differences will be examined via the experiences of IMGs working in the Far North of New Zealand. Their journeys from the US, Canada or the UK are expanded upon, from previous experiences to present challenges, in order to understand what motivates IMGs to work and then potentially settle in New Zealand rural communities.

Rural retention in the medical workforce has been an ongoing issue globally. In small rural communities that have suffered from a history of 'colonised hauora' (Moewaka Barnes & McCreanor, 2019), this high turnover of doctors undermines trust in medical services. The need for well orientated IMGs, may improve the chances of long-term retention by minimising acculturation stress, while also preparing them to provide culturally aware treatment in their new communities. This analysis will address the factors involved in providing an orientation programme that promotes healthy cultural integration, before illustrating how a localised, community focused approach to IMG orientation can prepare doctors to work with local Māori populations.

The importance of having IGM 'buy in' into the community via healthy cultural integration, focuses the initial discussion on the 'cultural distance' between the 'society of origin' and the 'society of settlement' (Berry, 2006). The personal histories and future expectations of the IMGs help to provide examples of protective factors that encourage resilience (Yu, Stewart, Liu & Lam, 2014). These descriptions provide a starting position from which to build an analysis of the push and pull factors involved in moving to rural New Zealand. As part of this analysis, the differences in how the IGMs view the practice of Western medicine in their home countries will be

discussed, with descriptions of practice in rural New Zealand as a contrasting element. The barriers to healthy acculturation will then be touched upon with an emphasis on how that may affect orientation and practice. This first analysis section will be concluded with a discussion about how rural locations provide additional challenges for IMGs looking to settle in the small towns or villages in Northland.

Personal History and Future Expectations

For most IMGs immigrating to a new country and adapting to new cultural or professional norms hold several challenges (Karla, Bhugra & Shah, 2012; Al-Haddad et al., 2022). It is difficult to acclimatize to all these challenges prior to immigration, so a degree of resilience is needed to allow time to acculturate. This was the case for the IMGs in this study who relied upon previous life experiences to mediate their integration into their communities. For some, previous moves either between or within countries had given them previous exposure to acculturation stress, before moving to the Hokianga:

> *"And so then moving to somewhere where if you hadn't lived there for the last three generations, you were an outsider… So, far worse culture shock." (Betty)*

Acculturation stressors may occur for individuals or groups when two different cultures come into contact (Berry, 2006). These stressors may be experienced psychologically as the individual struggles to adapt or adjust to features of another culture. However, these stressors can be mediated prior to immigration (Al-Hadadd, 2024). For example, the motivating factors for immigration may shape the perception of the new environment, and act as a protective element for doctors migrating to New Zealand. While adapting to a new culture will always be challenging, acculturation stressors may be navigated in part by knowledge, expectations and goals. The degree of difference between urban England, or the US and rural New Zealand could lead to a degree of acculturation stress, which potentially affects the initial experience of an IGM and by extension their practice. The context around every IMGs immigration shapes the potential for acculturation stress. Taking a broader view however, speaking the dominant language, having a high level of education and financial security act as protective factors against acculturation stress (Castro & Murray, 2010). How this initial contact with a new environment occurs, may also be mediated by the doctor's previous experiences with domestic migration or international immigration.

Previous Acculturation

Though there appears to be little research on the cumulative effects of multiple acculturation experiences on individual resilience for skilled migrants, it seems plausible that these experiences could help with cultural adaptation. The ability of the IMGs to adapt to their new environment in response to markedly different social, cultural and professional practices seemed to be aided in part by their previous experiences of acculturation (Al-Haddad et al., 2022). The American trained doctors discussed the challenges of moving within the US and meeting different attitudes and cultural norms that they were unaccustomed to. Agnes, who is from the Northeast of the US, found living and working in Texas to be difficult:

> *"But Texas was just an uncomfortable place in general. I felt like living in enemy territory and the politics have only gotten worse up there. So yeah, one more reason to not want to move home." (Agnes)*

The participants emphasised the degree of difference in political and cultural outlooks both between and within states. Coping with these intra-country differences may help to prepare IMGs for inter-country acculturation. For example, political and social conservatism was seen by these IMGs as inherent to certain locations, such as Texas on a state level and rural Pennsylvania on a within state level. These differences highlighted the political and social fault lines that occur in the US across States and the urban-rural divide (Gimpel, Lovin, Moy & Reeves, 2020). For Betty, the move as an adolescent from college towns around metropolitan areas to rural Pennsylvania was a bigger cultural shock than the move to Rawene.

> *"So it was that kind an area, and again, it was probably in retrospect, a good training thing to have gotten thrown into somewhere that was so culturally different because honestly, the culture shock of moving to Wilkes Barre as a 14-year-old outweighed the culture shock of moving to Rawene as a 30 something medical school of graduate. Just no comparison. Wilkes Barre as a 14-year-old is the worst culture shock I've ever experienced in my life." (Betty)*

These instances of culture shock occurred across different age ranges from childhood to well into a professional career, highlighting how robust this phenomenon can be across life spans (Xia, 2009). For another IMG, the experience of living and practicing in the UK for 25 years was prefaced by a period of acculturation that was challenging socially and culturally. The differences in interpersonal displays of affection and the social aspects of colleagues' relationships were significantly different than her experiences in Spain. Her respect for the professional culture and

quality of training in the NHS tempered some of these feelings, but the alienation of the overall experience seemed to still affect her:

> *"They will all think that you are odd because you are very touchy, and they don't like the physical contact. So, the first thing is, the normal thing is you meet somebody, you don't shake hands, you give them a couple of kisses and say hello and so on. So, this was completely different for me coming from a very Spanish sort of situation into a very British... I got used to the shaking hands and the restraining my hands and all that kind of thing." (Adelia)*

Adapting to a new culture is multi-dimensional, in that in that is not a "zero sum" process where all aspects or no aspects of a new culture are embraced (Castro & Murray, 2010). The diversity across cultural groups alone makes a unidimensional understanding of acculturation difficult to operationalize. There is however the potential for enculturation across skilled migrants working in small rural communities. For the participants, a mutual professional or academic background may act as a cultural waypoint from which to build a localised cultural grouping that acts as a protective strategy against acculturative stress.

Professional Confidence

Having the confidence in your professional ability as a doctor with years of practice experience appeared to be a shared characteristic that provided continuity from the IMGs old lives to their new positions. This faith in a professional identity may act as a protective factor towards acculturative stress (Zikic & Richardson, 2016). The procedural aspects of practice differed enough across health systems to be considered a stressor for the participants, but a belief in their ability to provide care seemed consistent. The tradition of biomedicine across Western culture provides opportunities to share similar experiences and offer collegial support.

> *"The culture of colleagues is very collegial here. Very collegial in both locations, so that's good. No looking down on you, no competition" (Agnes)*

Feelings of collegiality and openness are not surprising within New Zealand settings. While the idea of New Zealand as an egalitarian paradise have always been mythical, there is a much lower power distance than in many countries (Basabe & Ros, 2005), and a sense of casualness that pervades the culture (Bartley & Spoonley, 2008). Within this relatively supportive environment, the participants generally viewed the learned ability to diagnose and treat patients, within a biomedical setting, as a transferable skill that could be applied across different countries. Local

or cultural variations may have caused initial problems but having the identity and skills of a practitioner seemed to provide a degree of surety.

> *"Once you are a doctor, you cannot stop being a doctor. You are the doctor for life and that means whether you are paid or not, you have the mentality of a doctor, they need me, I do a type of thing… That is what they call vocational. I'm not sure whether other doctors feel the same, but I am a vocational doctor." (Adelia)*

Across the different stakeholders that I talked to, the belief that all medical staff in the region were being asked to do more and more for less, was a common theme. Adelia's comments on being a 'vocational doctor' suggest a level of commitment that may act as both a protective and a risk factor, in a small high need's community. Feeling vital to a community may create confidence and motivation in your role, whilst also increasing chances of burnout, putting doctors at risk, and ultimately affecting retention (*c.f.* Berry, 2005). Outside of these concerns, there are limits to this medical equivalence however, and ultimately, it is the space left between broad biomedical, clinical knowledge and the practical, cultural and social specifics of practice that an orientation process should address. Agnes, understood the limits of this medical equivalence across different societies:

> *"I don't know how to order a lab test. I know how to practise medicine, but I've never practised medicine in New Zealand. I know health pathways, I can do the formulary, but I just felt like every single thing was a struggle." (Agnes)*

Acculturation stress that is caused by feeling unprepared in a professional sense, has the potential to effect initial consultations with patients, increase initial job dissatisfaction and ultimately create an environment that can affect the chances of long-term retention for foreign care workers (Adebayo, Nichols, Albrecht, Brijnath & Heslop, 2021). The global features in rural medicine that make recruitment and retention of staff a consistent issue, also apply to rural Northland. Having continuity and cohesion in medical staff across time should increase trust in the service as relationships are built and maintained. The factors that lead to a long term, intensive commitment to a community involve where you have been, the challenges inherent in your new home and the prospects that this new environment holds. The next section will concentrate on the contextual factors that led the IMGs to practice on the other side of the world, thereby shedding light on the conditions that might be involved in long term stays in the Far North.

Pull Factors: Reasons for Immigration

The rationale behind moving from the other side of the world to practice medicine in rural Northland understandably varied across participants. While the MCNZ literature (2011) had pointed to defined reasons for migration, such as 'empty nesters' or 'adventurers', the reality was more nuanced. The lack of nuance in these categories supports the concept of a workforce that is unlikely to commit, long term, to the communities that the IGMs work in. However, the changing of personal circumstances and the eventual building of ties with the community can influence how the nature of an IMG's tenure in New Zealand is shaped, irrespective of age, marital status or children. One of the doctors, for example, would be classed as an 'empty nester' as she moved to New Zealand after her children had grown up and left the family home. This category is considered to be an end-of-career move, bordering on semi-retirement. She explained her reason for migration:

> *"I didn't come to work. I just came to have a holiday. But then I found particularly in that area, there were very few doctors and it's a little bit like it is now, very few doctors and that people need you and I had a lovely boss and he said, you want to stay? You've signed for six months, but do you want to stay a bit longer? And I said, let's try. That was a year and a half after." (Adelia)*

The relationships built with the community in Rawene and within Hauora Hokianga have superseded stereotyped conceptualisations of stage-of-life career choices. A more nuanced analysis points to career choices that are made by relationship building with a place and the people, rather than a predictable, linear path of behaviour. This perspective may point to recruitment and retention that is orientated towards a strength-based approach. One strategy in this approach may be providing specific information about the rural community that the IMG is about to work in, to clarify expectations.

Expectations

Expectations of medical practice in New Zealand were often shaped by friends, family, or colleagues. Medical migrations are common enough in many OECD countries that all my participants had known someone who had worked in New Zealand previously. Living and working in New Zealand was seen by others to be a good fit socially and professionally for some of the participants who were looking for a change of lifestyle or health culture. Richmond (1993) makes a distinction between reactive and proactive migration as a factor in acculturating to a new culture. Reactive migrations often occur in situations where the individual or group has

little choice, as in the case of refugees. The IMGs in this study all made proactive migrations to New Zealand and this element of choice may have improved their chances of healthy integration. Prior knowledge of the host country is viewed as a protective factor in cultural adaptation (Kosic, 2002). In two of the cases, colleagues had recommended New Zealand after working here.

> *And then this partner of mine came to New Zealand for a sabbatical for six months to Auckland. He was very impressed with the New Zealand sort of approach of life and all that kind of thing. And when I said I was going to retire, he said, I think you should go to New Zealand and work for a little while in there because it's a completely different setting and you are going to like it more than what you like England. So, I came for a holiday and that was 12 years ago. (Adelia)*

This may have prepared the IMGs for their new lifestyle, though they were quick to point out that second hand information cannot fully capture the degree of difference. The participants appeared to have found a balance between prior knowledge and the acceptance that the environment may be different from what they expected. This is important because there is an argument that extremely proactive motivations for migration, can set up unrealistic expectations for the migrant (Richmond, 1993). One of the doctors who was born and raised in the US had a mother from New Zealand and had a childhood full of stories about growing up in Taranaki. This prior knowledge helped to prepare her in part socially, if not professionally for life in the Hokianga.

> *"And so, I actually feel like that prepared me for being here pretty well, because culturally, I grew up with Kiwi relatives and I've been here plenty of times before over the years, so I knew some degree of New Zealand culture." (Betty)*

At one stage, Betty used the example of having Footrot Flats books in her house growing up. This comic strip depicts farm life in the late 1970's to the early 1990's in rural New Zealand. The themes explore the difficult aspects of this lifestyle in a dry, comedic way, which may still represent an aspect of New Zealand society and prepare you for some of the cultural differences with the U.S. The potential acculturation stress caused by cultural distance may have been mediated by the level of prior knowledge before immigration. While there were aspects of professional adaptation that were needed, there was enough of a realistic idea of her new environment, that integration was easier than for someone with no prior knowledge. There are, however, limits to the universalism of New Zealand culture, even before the bicultural nature of the country is accounted for. Expectations, or prior knowledge may aid initial adjustments to a

new cultural environment, but other motivations are needed to improve integration. Considering the lower socio-economic conditions of many Northland towns, an appetite to assist in underserved communities is a useful motivation to hold.

Serving the Underserved

For rural practices, recruiting New Zealand trained doctor's is a long running issue (Garces-Ozanne, Yow & Audas, 2011). The reasons behind the difficulties in recruiting New Zealand trained doctors into towns like Rawene is not thoroughly understood. However, in the US, 35% of IMGs were more likely to want to work in disadvantaged areas compared with 21% of white non-Hispanic US born doctors (Weissman, Campbell, Gokhale & Blumenthal, 2001). It is difficult to explore the rationale behind this desire in the literature, but it was a common theme amongst participants. Betty discussed both her and her brother feeling a drive to work with under resourced communities:

> *"But we both basically work with what we can to provide healthcare to people who don't have resources." (Betty)*

This desire of IMGs in the US to practice in low-income areas may reflect a similar attitude internationally. Agnes seemed to enjoy the patient populations in these demographics and found the public health system in New Zealand allowed her to provide the services that were needed, which was an area of frustration and distress in the US. She discussed having prior experience of working in underserved communities by comparing working in urban US environments and Rawene.

> *"So then for the last two years before I came here, I was at the community health centre, which was more like this population, it's just underserved, impoverished, lots of diabetes and hypertension and out of control stuff and people without a lot of resources to manage it. So that feels familiar coming here." (Agnes)*

This preference, allied with previous experience in low SES areas or treating minorities in their home countries, could potentially act as a protective factor in smoothing the acculturation process. There may be a relationship between the desire to serve disadvantaged communities and the subsequent preparedness for those settings (Weissman, Campbell, Gokhale & Blumenthal, 2001). There is a link between having an intellectual appreciation for working in low SES settings and a deep appreciation of these communities that acts not only to build resiliency but to also add meaning to these doctors' lives (Stevenson, Phillips & Anderson, 2011). Deriving

meaning from work that often involves long shifts and (as previously discussed) relatively poor renumeration is important as a protective factor in acculturation. These push-pull elements in every immigrant's journey provide contextual factors that may encourage resilience against initial acculturative stress. There are, however, larger challenges at play when immigrating to culture's that are far removed from your own experiences. The importance of a comprehensive orientation programme for IMGs becomes a priority when the specific difficulties of cultural adaptation are accounted for. A discussion of these difficulties will be considered in the next section with a more detailed exploration of different medical cultures, patient presentation, and the effects of time pressure on local orientation programmes.

The Difficulties of Cultural Adaptation

Orientation programmes cannot necessarily account for the variation in IMGs past experiences and the unique push-pull factors involved in choosing to immigrate to New Zealand. There is scope however for acknowledging the potential difficulties in adapting to the new host culture and providing guidance in those areas. The participants detailed how the differences in setting and belief systems affects how successfully they can integrate into the local culture. All the IMG's enjoyed the community they worked in currently, so examples of cultural maladaptation could only be drawn from other experiences in New Zealand. Adelia, who had worked in other regions of New Zealand discussed feelings of alienation during a stint in a South Island town:

> *"From the first day I was telling my husband, I'm not coming tomorrow, I'm not going tomorrow. I'm not going to work tomorrow; I'm going to resign. So, every single day for the two weeks that I was there, I was telling my husband, I'm not coming." (Adelia)*

The sheer number of adaptations that need to be made, make short term adjustments in this situation difficult. These experiences place pressure on individuals who have committed to an unknown environment far from what they know. Multicultural settings have numerous levels of knowledge that take time to understand and may involve trying to 'know' concepts outside of didactic learning. Additionally, the way medicine is practiced across the professional sphere is not only different across countries but also within countries (Corallo, Croxford, Goodman, Bryan, Srivastava & Stukel, 2014). For the participants, these differences are shaped by how rural New Zealand and/or local Māori patients think about illness and how these thoughts are presented, as well as workplace culture, and the specific challenges of living in under resourced rural

locations. To understand the challenges that orientation programmes need to address, I will first analyse how the time constraints effect how these programmes are structured and experienced.

Time pressure

The consequences of staff shortages play a significant role in local orientation approaches. According to the participants, there is initial pressure on all stakeholders to get the IMGs settled and into consultations as quickly as possible. This doesn't seem as much a choice, as a necessity. This pressure leads to rushed orientation processes that provide the very basics of living and working in the community. In Rawene, hospital housing is provided, which provides a basic foundation to initially build upon. As explained here by Betty, the manaaki of the hospital staff also softens the first few days in the Hokianga.

> *"So, I arrived in Kerikeri on Wednesday night, was picked up by the person who had (sic) done the bulk of their recruiting stuff… So, she picked me up from the airport, brought me back, showed me the house that I was going to be staying in. At least they provided housing. And then kind of looked at me, looked at the situation and went, how about you drop off the bulk of your luggage and then come back with me to my house and I'll feed you and to give you some place to sleep tonight so that you don't have to be stuck in a room by yourself in a new country. All the rest of it." (Betty)*

Learning the systems of the medical centre and the medical software used by the organisation is a major concern for doctors starting in a new practice. The IMGs struggled with the time allotted for this transition. The timeframes for adjusting to the software programmes like MedTech was reported as being as brief as a morning session. Comparatively, if this is the length of time given to a doctor's primary concern, then other factors, including the nuances inherent in all cultural interaction's, must be ignored entirely. The extent of this time pressure and how it affects orientation was expanded on by Agnes who underlines not only feelings disorientation but also the regional variance across New Zealand:

> *"Yeah, at that point I had nothing. So, any information was good information, but then you don't get to apply that until you're in it. So, three days of that and then flew up here and started work at* [the initial practice Agnes worked at] *and literally spent the whole morning going through med tech with one of the other doctors and then they booked us with patients for the afternoon. And it wasn't a lot of*

patients, it was like one an hour or something, but still we knew nothing. I was with one other locums and we both were like, what is even happening? I don't know how to order a lab test. I know how to practise medicine, but I've never practised medicine in New Zealand. I know health pathways, I can do the formulary, but I just felt like every single thing was a struggle. And then we got this email from one other, from these folks who went to the south island and they said, oh, we were training for two weeks before they made us see a patient. We were like, oh, that would've been nice. It took me two to three months to even begin to feel like I knew what I was doing." (Agnes)

The shortcomings in the orientation processes need to then be improved upon by the medical organisations. However, aside from the odd anomaly, there is little in the way of funding or guidance for these organisations looking to provide locally relevant cultural orientation. This lack of guidance is further complicated by the sheer pressure on practices to provide fully staffed services, particularly in rural areas. In short, it is difficult to allow doctors the time for education, whether as instructors or students. Underlying this lack of resources perhaps is a lack of care at a national health policy level. The assumption is that all Western trained doctors can be inserted into all Western settings. However, the ways that different cultures experience ill health globally necessitate approaches to orientation that reflect more nuance rather than universality. The IMGs arrived in Northland to a markedly different and specific medical culture that needed to be adjusted to.

A Different Medical Culture

It is expected that all immigrants starting employment in their host countries will have a list of work-specific-concerns and the IMGs in Northland were no different. Whilst biomedicine has a relatively consistent application across most OECD countries, there are differences in treatment, pharmaceuticals, medical software and patient presentation that make individual countries medical cultures unique (Corallo, Croxford, Goodman, Bryan, Srivastava & Stukel, 2014). Agnes discussed the extent of the differences between US and New Zealand practice:

"Oh no, here's way different. Yeah, here's way different. Other than also being English speaking, I have to look up every medication because the names are different. And some of the ones you have, we don't even have, and you have a pretty smaller amount of each medication class and there's nothing wrong with

that. That's actually fine, that's great. But still I'm doing a lot of just on that level." (Agnes)

Whilst the NZ Locums orientation had touched upon some of these topics, the amount of difference under time pressure from bookings places IMGs under pressure. Identifying and dealing with these differences are a substantial stressor for IMGs in new countries (Iorga, Soponaru, Muraru, Socolov & Petrariu, 2020). These skills often must be acquired after a few days of instruction, followed by practical application in consultations shortly after. Learning these skills seem to be the highest priority for doctors throughout orientation. For Betty, knowing the parameters of the role, such as when and where to refer patient's, was an important step in feeling competent in her new environment.

"To feel like I kind of knew what I was doing was probably three months to feel really confident that I could handle the entire system and knew what was going on, where to refer and what I'm supposed to be doing." (Betty)

The 3-month period that Betty brought up is a reminder that some knowledge is difficult to acquire without the day-to-day context that experience allows. In saying that, a more comprehensive orientation process may speed that process of learning up. Shortening the period that an IMG takes to feel at ease with their role could improve retention, as the risk of being overwhelmed in that timeframe may lead to an early departure from the position.

The organisational attitudes towards new doctors were viewed as a major barrier to acculturation, job satisfaction and ultimately retention. Workplace culture inside and outside of the professional sphere may make the learning of specific skills easier, as professional and social support can ease several factors leading to work related stress (Aalto, Heponiemi, Josefsson, Arffman & Elovainio, 2018). None of the participants felt that they were unsupported professionally, in their current positions, but experiences with previous practices had underlined how important collegiality is.

"So, I had a long commute, and I didn't know anybody and there was no socialising outside of work. Even though I love the [previous practice] folks, they're great. We had a good time at work, never was anything happening outside of work with those folks." (Agnes)

Informal conversations across professional and social settings provide opportunities for IMGs to discuss and process the differences in approaches to health across cultures. Zwack and

Schweitzer (2013) found that the "exchange of views and experiences with colleagues was the central resource for reduction of professional insecurity" (p. 387) across German physicians. The complexity of cultural exchanges may drive a need for a supporting collegial environment where these conversations have the potential to improve understanding across the medical staff. Patient presentation in rural New Zealand and/or amongst Māori patients may present challenges or differences that exemplify the complexity of these exchanges.

Staffing Shortages

The difficulties in staffing medical centres were an ever-present topic of conversation across all the participants. While there are reported difficulties in recruiting GPs in many regions of New Zealand (Danish, Blais & Champagne, 2019), the shortages in Northland seemed particularly severe. These shortages affected the running of the practice/hospital, the orientation process, and the quality of life for the staff. The overall issue seemed to be that staff shortages created an environment where every aspect of treatment (satellite clinics, the Emergency Department, hospital clinics and paperwork) was impacted upon. Betty discusses the knock-on effects of staffing shortages:

> *"And we also didn't have enough doctors to ensure that every peripheral clinic session that would normally happen would be happening. So, some of those were getting cancelled as well, which meant that there were more, and Rawene clinic was fairly regularly down to one doctor having a half of day, and that was all that we could spare to be able to do that. And so, all of that excess need fell on accident and emergency and the two of us." (Betty)*

The inability to cover some of these services seemed to take a mental toll on the doctors as they were physically and psychologically tired from covering various roles. Regarding the orientation process, staffing shortages directly affected the amount of time allotted to teaching new IMGs about the hospital systems. A lack of staff, places pressure on management to get new GPs into patient consultations as quickly as possible.

> *"Yeah, I think (the Clinical Manager) was like, I asked him about it, and he was like, well, one, you're an expensive employee and we need to get you working. And two, they're really short-staffed. So, because that would slow down that doctor if they had to do that. So then that doctor's schedule would have to be probably a little more loosely booked." (Agnes)*

The pressure on clinical managers to get new IMGs working in clinics quickly, highlights how (a lack of) resources impair policy decisions. It also underlines a constant uneasy balancing act that exists between financial imperatives and providing a comprehensive health system. This is contrasted with practices in the South Island where this lack of pressure leads to longer more thorough orientation. Agnes discussed the variance in orientation duration across New Zealand for IMGs:

> *"And then we got this email from one other, from these folks who went to the south island and they said, oh, we were training for two weeks before they made us see a patient." (Agnes)*

This variance may point to intra-country inequality and is supported by other measures of health provision such as waiting times (Pearce & Dorling, 2006). The colleague that Agnes was talking about worked in the Nelson-Marlborough region, which has hospital wait times that were almost five (4.98) times faster than Northland (Te Whatu Ora, 2023). Over time, these inequities in resourcing can shape how patients experience and approach ill health. It appears that IMGs are often unaware of these contextual historical factors before starting work in New Zealand. Patient presentation in rural Northland was viewed by the participants as different from other locations that they'd practiced in.

Patient Presentation in Rural Northland

How different cultures experience and seek help for ill health differs markedly across time and place (Macintyre, Ellaway & Cummins, 2002). The IMGs that discussed the differences in health seeking behaviour in New Zealand were surprised by the extent of those differences. There was general shock at how 'bad' the illness had to be before patients went to the medical clinic. For example, Adelia felt that,

> *"The type of presentation of patients in New Zealand is completely different than the type of presentation of patients in England. I found that in England we had a lot of, at least in the surgery when I worked, we had a lot of worried wave people that will come and say they have to look at my finger. And in here people will come with a head falling down like this and say, doctor, it did fall down. What do I do now?" (Adelia)*

This may reflect how attitudes to health seeking behaviour differ across the urban-rural divide, particularly regarding mental health (Pearce, Barnett & Jones, 2007). Access to services can be a

problem, but the hesitancy to seek help may be more inherent to the culture. A more nuanced view of rural access hints at the need for health services to be responsive to the unique needs of their communities above and beyond the proximity of services. These unique needs are supported by different patterns of health seeking behaviours. An example of this variation is evidenced by the markedly lower attendance rates of rural males aged 25-44 seeking treatment for mental health problems (Fraser, 2008). Within this subset, Ferris-Day, Hoare, Wilson, Minton and Donaldson (2021) suggested that fear of gossip within small rural communities was an impediment to seeking care either at the closest possible clinic or at all. Whilst this may be true, the pattern of behaviour could be tied more to feelings of self-reliance and an overall sense of understatement in rural culture. The necessity of being self-reliant over generations may create an atmosphere where seeking care is the last resort. A lack of resources supports these prevailing attitudes as access to specialist services are difficult to obtain. As Agnes pointed out:

> *"You barely can get them in to see the specialist. So, I mean, at the beginning I was like, people would walk through the door in Broadway, and I'd be like, oh, that's going to the hospital. And the nurses were like, no…" (Agnes)*

The inability for GPs to access specialist treatment for their patients also leads to a broader scope of practice. The shock in having to deal with conditions that are outside of the usual practice parameters is an area that could also be incorporated into orientation programmes. As previously stated, the IMGs ultimately prefer using a wider scope, but those practices take time to reengage with:

> *"I'm like, okay, walk me through it, but so many things that would've been automatic hospital visits in the States are like, no, we deal with that." (Agnes)*

Participants found that attitudes to seeking care were seen as significantly different in New Zealand when compared to patients in the US or UK. The increased scope of practice negatively (Coutinho, Cochrane, Stelter, Phillips Jr & Peterson, 2015), combined with a reticence from New Zealanders to ask for help when ill or injured, has taken some adjustment for my participants. As addressed by Betancourt, Green, Carrillo and Ananeh-Firempong II (2003), cultural differences affect "…variations in patients' health beliefs, values, preferences, and behaviours" (p. 118).

The attitudes to health seeking amongst patients in rural Northland is possibly more localised or culture-specific than is understood by New Zealand health policy makers. Potentially, an awareness of this nuance is an important step in improving health provision for minorities.

There may be an assumption underlying many state health organisations that IMGs need to be assimilated into a professional and social monoculture, irrespective of the needs of indigenous cultures, minorities, or the IMGs themselves. This is supported by much of the research on the topic (Hall, Keely, Dojeiji, Byszewski, & Marks, 2004; Pilotto, Duncan & Andersson-Wurf, 2007; Kehoe, McLachlan, Metcalf, Forrest, Carter & Illing, 2016) where the epistemological foundations are geared towards ethnocentric adherence. The emphasis is often on monoculturalist values or skills such as English language acquisition or addressing power imbalances in consultations. However, orientation programmes that fail to address the nuance inherent in the diversity of cultures across locations, must rely on an assimilationist belief in monoculture. To not cast the net wider, is to do a disservice to minority cultures and the IMGs themselves.

In the second chapter of this analyses, I will discuss how the specificity of time and place should be utilised to orientate IMGs into rural Northland communities or kāinga. The particular focus will be on the initiatives being undertaken by Hauora Hokianga and health leadership within the Hokianga, who are preparing the soil for a unified community health approach through decolonization and reconnection. The hospital marae will be placed in the centre of a movement in Hauora Māori where traditional approaches to indigenous wellbeing such as rongoa are provided alongside culturally safe Western treatments. Expert witnesses also provide a thorough insight into the importance of localisation as a vehicle for cultural awareness training and orientation programmes.

Chapter Four: 'Health in the Centre of the Universe'

The Hokianga has been described to me by locals as the 'Centre of the Universe'. This conceptualisation of their home as being at the middle of existence as we understand it, is a vital element in understanding where hauora (wellbeing) is located for Māori of the Hokianga. How local Iwi view orientation programmes for IMGs stems from their own relationship with this environment and the interconnectedness of land, people and culture. The importance of mana whenua (land) to Māori health is explained by Moewaka-Barnes and McCrenor (2019) who note that: "Connections with whenua are of interest to public health, not just for wellbeing potential in terms of, for example, connections with nature or opportunities for physical activities and social interactions, but in terms of what places mean to people and the relationships we have, ideologically, emotionally and spiritually" (p. 29). Hond, Ratima And Edwards (2019) underlined this interconnectedness in their research on māra (community gardens). Hauora is located in a cultural identity that is rooted in the Hokianga, not in a broader idea of Māori. Currently, Hauora Hokianga (Hokianga Health), the health provider of the Hokianga region has undertaken a 2-year trial to assess the feasibility of a cultural awareness programme for kaimahi (staff) that delivers cultural awareness training from a localised perspective. The first section of this chapter examines the cultural backgrounds of IMGs, the challenges involved in medical migration and the support offered at a national level within New Zealand. This section begins by addressing the importance of localised orientation; discussing how decolonization is central to hauora; how reconnection as the pathway towards decolonization; and finally, how these threads have been interwoven to create the current cultural awareness programme for kaimahi (and IMGs), Te Takapau Taonga.

The Local Experience

As presented in the beginning g of this chapter, the responsibility for orientating IMGs to rural Māori communities falls on local health organisations, after the doctors are exposed briefly to broad universalistic concepts of Te Ao Māori (Hauora Taiwhenua, 2023). NZ Locums, a department of Hauora Taiwhenua Rural Health Network (HTRHN) is presently contracted by the New Zealand government to provide orientation and ongoing support for rural medical organisations. One rural participant, Lynn, who worked outside of the Hokianga, praised the orientation provided and underlined the use of outsourcing this process in contrast with IMGs that arrived with no orientation experience. Her experience as both an IGM from Canada and

practice owner, offered an insight into how different attitudes towards IMG orientation could be across Tai Tokerau:

> *"Well, the second time we came back, I went through, because I knew where I wanted to come and I had contacted the practise and then to help with all the immigration and medical council applications, we'd actually, because they get free use of NZ locums, so then we'd made contact with them. So, then I did go to the orientation programme in Wellington, and it was like, oh, this would've made my life a lot easier at the time." (Lynn)*

In the Hokianga, the ties with HTRHN are present, but the IMGs of that organisation generally believed that there was a disconnect regarding orientation at a national and local level. This feature of the overall orientation approach is potentially the most worrying. The amount of previous experience with indigenous populations or previous experience with New Zealand doesn't seem to factor into orientation at a national level, leaving the local medical organisation to provide most of the initial information, particularly regarding the cultural aspects of care provision. This disconnection is unsurprising when the vagueness of the MCNZ (2011) guidelines is considered. The communication across the local and national level may be adequately mediated by HTRHN, but there seems to be little appetite for comprehensive orientation at a community specific level. This may reflect the homogenised view of Māori at a national policy level, thereby amalgamating the unique outlooks of numerous iwi and tribally disenfranchised Māori. A kaumatua, Hāre, of the Hauora Hokinga marae, Te Pou Kara Ariki reiterated that point consistently during our discussions:

> *"And part of…the hospital itself realising that it has never been connected probably with the community itself. So, this is a time of reconnecting. This is a time of rebirth. This is a time of being Hokianga, knowing Hokianga smelling, Hokianga living, creating and dying with Hokianga on a daily basis." (Hāre)*

While there are some lectures on Māori health during the three-day HTRHN orientation, it seems unlikely that they could cover enough of the pertinent cultural, historical or social nuance involved in the topic. The responsibility therefore falls to local medical organisations that are under pressure to provide services in the face of staff shortages, a fragmented health system and a dated funding model for Primary Health Organisations (PHO) (Goodyear-Smith & Ashton, 2019). In the case of Rawene hospital and Hokianga Hauora as an organisation, the onus for a localised orientation process has been fully undertaken (Blattner, Stokes, Rogers-Koroheke, Nixon & Dovey, 2020). The participants emphasised the pressure that the hospital is under

regarding staffing, but also the care that goes into cultural orientation. This process has been formalised in the last year into a cultural training programme for all kaimahi (staff) including beginning IMGs called Te Takapau Taonga. To understand the potential of this approach, a theoretical context needs to first be provided. The hospitals policies, driven at a local or national level provide only part of the story. How the Iwi of the Hokianga are beginning to reconnect with traditional approaches to wellbeing to decolonise their ways-of-being, plays a significant role in providing IMGs with understandings that are relevant to local Māori.

"There is No Ao Māori in the Hokianga"

The Māori world consists of "diverse realities" (Durie, 1994, p. 214) that are dynamic, contradictory and complex. As previously mentioned, the intensive urbanisation of Māori has created sub-cultures where ties to rohe potae (tribal territories) vary from being significant identity markers, to the experience of complete disenfranchisement. In between this broad continuum, there is also the ways in which Māori reproduce traditional cultural practices across urban landscapes (King, 2019). For my participants, the location of hauora for the people of the Hokianga was in the specific cultural context of the Iwi Māori of the Hokianga. The Kaumatua consistently reiterated the importance of holding a cultural identity that starts with the Hokianga as a kāinga (settlement) and is differentiated from other Māori.

> *"As in there is no Ao Māori in the Hokianga, that's a Pakeha perception. There's only hapu, there's only papakāinga, there's only iwi…. We're not Auckland, we not Whangārei, we don't even whakapapa to those areas…The only thing that keeps us together with the ministry is our contracts. So, all of those things become very relevant now of how we express ourselves, what we do, how we even write certain reports and stuff" (Hāre)*

Panelli and Tipa (2007) discuss 'therapeutic landscapes' in terms of how hauora is located in and specific to Māori rohe potae. Focusing the orientation programmes for IMGs on the cultural practices of the iwi of the Hokianga is supported by the idea that studies: "…highlight the importance of place-specific analyses because experiences of well-being vary with a composite pattern of elements unique to each location" (Panelli and Tipa, 2007, p. 448). The interaction between the land, the people and turangawaewae (the place where you feel connected to) within Māori cultural further emphasises the need for a place-specific approach to orientation. The Hokianga region is tribally home to three iwi: Te Rarawa, Ngāpuhi and Te Roroa. The participants viewed the needs of our people in this rohe potae as specific to us, not a generic

sense of Te Ao Māori that can often be part of national level induction processes. Manaia, who was an assistant of the kaumatua, added her thoughts about the rohe, as someone who was from the Hokianga:

> *"Well, the water. People may say it disconnects us, but it actually still connects us… we can come off all three different iwi, come off Te Rarawa, we come off Ngāpuhi and we can also come off Te Roroa." (Manaia)*

This distinctiveness is particularly important considering universalistic representations of Māori within national health promotion approaches (Kukutai, 2004). Even by taking into account the impracticalities of applying this approach at a National level (such as timeframes), an orientation programme that incorporates cultural awareness, would struggle to capture the nuance across different Iwi or the urban-rural dynamic. The tension between universalistic and localised conceptualisations of indigenous health reproduces itself in some of the literature being produced by the hospital organisation:

> *[looks at a flyer sent out with 'Te Ao Māori' on it]: "One of our workers sent this out to our local schools thinking that from a pakeha person's point of view that that was okay, but from our point of view, you shouldn't have done that. There is no Ao Māori inside the Hokianga, there is no such people inside Hokianga. What we are saying to them, please, if you're going to send that anything to do with, if you're, you're expressing your cultural element to someone as on behalf of the hospital, please include us so that we create the correct heading so that it has meaning behind it." (Hāre)*

Representations of local Iwi knowledge that aren't tika or correct, are not just viewed as misrepresentational, they are seen as perpetuating colonization. In this regard the knowledge is not the hospitals to give and reifies pakeha control of local Māori experiences (*c.f.* Cram et. al., 2006). The intention to promote local Māori health is there, but the correct processes are not. However, part of the process of reconnecting, is strengthening or building the ties between the hospital and local Iwi through the hospital marae, Pou Kara Ariki. Cultural misunderstandings are seen as part of the journey towards educating kaimahi about local tikanga:

> *"And one of the great things about the hospital that they've now come to the conclusion that any new, they come to the hospital no matter what title that they might hold, they've got to go through this cultural pathway as part of the*

integration for five weeks of the integration. It's not integration, it's… connection." (Hāre)

As will be touched upon later in this analysis, the Te Takapau Wānanga and Takapau Taonga initiatives are the formalised cultural awareness programmes that are specific to the needs of local Iwi. The history of the interaction between local Iwi and settler culture is complex and the movement towards decolonisation will take time (*c.f.* Huygens, 2011). However, the relationship between Iwi and Hauora Hokianga is attempting to create an environment that provides an informative, safe and warm starting point for IMGs starting at the hospital. As one of Te Takapau Wānanga staff explained:

"We're the first people that welcome you into as a kaimahi, so we have all our pōwhiri, all our new whānau to Hauora Hokianga, like you spoke about international students, they all come through here." (Manaia)

Some of these connections are formalised and others are examples of characteristics that are inherent strengths in the area. There is a belief that the warmth of the host organisations welcome and the effectiveness of their orientation programme encourages long term retention in rural hospitals (Stenerson, Davis, Labash & Procyshyn, 2009). These factors are seen as a strategy that may work to minimise the perceived downsides of rural practice, such as isolation. The tikanga Māori concept of manaakitanga, in this context involves practicing hospitality, respect and care (Wilson, Moloney, Parr, Aspinall & Slark, 2021). The participants felt that manaakitanga was important to the ease of their adaptations into the community. Betty, who had faced a long international flight, a brief orientation in Wellington and a journey to the Far North within four days, underlined this kindness:

"And then kind of looked at me, looked at the situation and went, how about you drop off the bulk of your luggage and then come back with me to my house and I'll feed you and to give you some place to sleep tonight so that you don't have to be stuck in a room by yourself in a new country. All the rest of it." (Betty)

Formalised welcoming ceremonies like pōwhiri are an opportunity for IMGs to have firsthand interaction and to begin building connections with local tikanga Māori before they begin practice in the community. These interactions based in traditional settings can improve cultural competency and understanding for medics (Jones, Pitama, Huria, Poole, McKimm, Pinnock & Reid, 2010). Pōwhiri are formalised rituals that allow the hosts to welcome guests onto the marae (traditionally) or workplace. Pōwhiri, "…were developed to manage risk and mitigate any

potential harm to ensure the survival and wellbeing of the community" by weaving people together via the acknowledgement of the mana of both parties as well as providing opportunities for displays of manaakitanga (Duncan & Rewi, 2018). In modern New Zealand society there is the possibility of these practices being construed as tokenistic or corporatised (Opai, 2021), but for the stakeholders involved in IMG orientation, in the Hokianga, the experience is essential. The warmth of their greetings and the sharing of food played a significant role in orientating them into their new positions. All the participants felt that the pōwhiri was important to their orientations. Betty, believed that the hui reestablished her links with New Zealand:

> *"Yeah, a little bit. Not too bad. And so, then she brought me over on Thursday morning and we had the Pōwhiri and so I got my welcome here and again Kiwi. So at least I knew kind of what I was getting myself into, but it was incredibly emotional for me actually because it was the first time that I'd been to something like that, and it felt like it was real. Yeah. It was for me, and it was an actual introduction to welcome to this country that has always been part of who you are…" (Betty)*

The impression across the participants who took part in a pōwhiri was that it helped to acknowledge them as part of the wider community. Te Pou Kara Ariki was used to host the pōwhiri, thereby strengthening the connections between the IMGs, local Iwi and the hospital. The way in which pōwhiri are conducted is also specific to the hapu or marae, thereby reproducing the uniqueness of the local Māori community against a backdrop of pan-Māori cultural competency training. The importance of the marae to the orientation process cannot be forgotten. Pou Kara Ariki can be conceptualised as a hub from which fundamental Māori health concepts can be accessed by the local community in conjunction with Western medical practice. The marae is located in the hospital and is an open space for patients or staff.

> *"Like I said, I think with the whole restructure of everything, everyone's still navigating, but we're still here like matua mentioned before, we're kind of the connectors. So, we are trying to ensure that we still remain connected within our organisation as Kaimahi as whānau, within, as well as our outreach of our whānau, hapu and our marae…" (Manaia)*

The desire to embrace kaimahi as whānau is central to cultural awareness initiatives with Te Takapau Wānanga. These efforts appear to be working as the feedback from the IMGs reiterated the camaraderie of the organisation. Consequentially, the receptiveness and manaakitanga of

the health organisation and the uniqueness of the environment play an important role in healthy integration of the participants and increased the chances of long-term retention. The doctors discussed the warmth of their welcomes, the ongoing supportive social environment the 'specialness' of the people in the community:

> *"So even though I'm here by myself, I sort of have this instant group of people that I could socialise with, and I love the patient population. I really find them to be just so gracious and welcoming and grateful that I'm here." (Agnes)*

The graciousness of the welcome that Agnes discussed however, occurs despite numerous social factors that are the result of ongoing colonisation in the region. The resilience displayed by the local community stems from efforts across the kāinga to address inequity on its own terms. The link between decolonising actions and improvements in indigenous health, is well established albeit with a caveat of 'improvements' not being linked to colonising paradigms (Paradies, 2016). Put simply, there needs to be fertile soil from which to grow strong relationships between the IMGs, Hauora Hokianga and the community. Part of preparing that soil is in recognising the strengths that are historically present in the local Māori community via a process of decolonization. Various stakeholders feel that there isn't an appetite for continuing purely biomedical Western approaches to health in the community. The movement towards decolonization across the community is viewed as being interconnected with the revitalisation of hauora Māori. As will be discussed in the next section the hospital marae is a hub that connects different stakeholders by embracing traditional ways-of-being and providing instruction on culturally aware Western medical practice. This is central to decolonizing efforts in health provision and by extension orientating IMGs in a way that prepares them to work with the Hokianga.

Decolonizing factors

The ongoing effects of colonisation continue to effect Hauora Māori (Moewaka-Barnes % McCreanor, 2019). These effects persist "through land alienation, economic impoverishment, mass settler immigration, warfare, cultural marginalisation, forced social change and multi-level hegemonic racism, Indigenous cultures, economies, populations and rights have been diminished and degraded" (Moewaka-Barnes & McCreanor, 2019, p. 19). The effects of colonisation on Te Rarawa, Ngāpuhi and Te Roroa in the Hokianga can be understood in part through health statistics and other measures of the social determinants of health. For example, compared with the rest of New Zealand (31.3%) nearly half (49.7%) of the inhabitants of

Hokianga North are not part of the workforce (Stats NZ, 2023). Colonisation has affected indigenous peoples globally, but how the effects of colonisation are felt, is specific to the experiences of individual communities through time and location (Axelsson, Kukutai & Kippen, 2016). This is pertinent to individual Māori health where the loss of whenua is interconnected with tribal identity and practices. The Kaumatua championed the need for a change in attitudes to address the effects of colonization in the Hokianga:

> *"People call it a programme, people say, but no, we call it, we call it movements. It's not a programme. We're not programming people. It's a movement. It's a pathway. It's experiencing life in its poorest manner compared because we class the poorest class, the useless people class, the most unemployed.... And how's that possible from a place that has produced iwi: has produced Te Rarawa, has produced Ngāpuhi, has produced Te Roroa nē, we have produced it all on there. How's that possible? Because of colonization." (Hāre)*

Loss is seen in the literature (Mark & Lyons, 2010; Axelsson, Kukutai & Kippen, 2016; Moewaka-Barnes & McCreanor, 2019), and by Māori participants, as the key characteristic of colonisation. A loss of identity, practices and the interaction between the land and the people have all affected traditional ways-of-being. For the three iwi of the Hokianga, these losses have direct consequences to health and wellbeing. For Takapau Wānanga the redress of this historical environment begins with whakapapa and the quality of whanaungatanga amongst the kāinga as a foundation to reculturalization:

> *"Whakapapa, what is that connection, equality of that connection? What does it look like? Because the quality connection means that is the quality that you are (sic) knowing that you're standing inside the quality and you're able to work with, talk to and walk alongside our people and such, but all the different generations, babies, the older people up here at the hospital itself. So, we are in a space of decolonizing ourselves and we're reculturalizing ourselves there." (Hāre)*

The need to decolonize health is viewed as a movement that must start from within the Hokianga and with practices that reconnect with traditional ways-of-being such as tuku kupenga (gathering food) or korikori tinana (traditional exercise). Though orientated toward empowerment, there is a recognition that the effects of assimilation policies have negatively affected hauora Māori in the rohe. The prevailing thought from the Kaumatua was that the approach of the last hundred years was not working and a return to traditional practices was the way forward:

> *"How did the old people survive in the past? What did they do to the land? What did they do to the bush? What did they do to themselves? Before the pakeha came? Even when the pakeha did come…we've all been pakeharized, it's all inside our blood, but it hasn't worked for us now. So, we've got to go back and work hand in hand." (Hāre)*

A belief that addressing Iwi health needed to be approached internally via reconnection, but also externally via structural change, was a key characteristic in conversations about the future. Building a stronger cultural identity helps to build resilience in indigenous communities (Castro & Murray, 2010). This empowerment perspective runs counter to the consistent government emphasis on negative health statistics and individualised health promotion. The external factors in local decolonisation involve the hospital environment, cultural awareness programmes and changing attitudes. The cultural awareness programmes will be investigated further in this chapter, but the need to decolonize the environment is interrelated. Hāre discussed the need for the hospital environment to reflect the strengths of the Hokianga:

> *"But with regards to the hospital itself, it is (sic) been a long, long time coming for the hospital. And I believe the hospital is still at 1% of what a hundred percent should look like as in what we have here. Because you go upstairs, it's different again, so you can see that this is a Māori element, yet the whole hospital is a Māori, you go somewhere else. Oh, I think I'm in Wellington. But that's not Hokianga. That's not Hokianga." (Hāre)*

The need to reindigenize the hospital landscape is in keeping with Kepa Morgan's Mauri model (2008). The Mauri model utilizes holistic indigenised realities to help to shape environments that promote mauri, described by Māori Marsden as "the bonding element that knits all the diverse elements within the Universal 'Procession' giving creation its unity in diversity. It is the bonding element that holds the fabric of the universe together" (2003, p. 44). Providing an environment within the hospital space is seen as an important step in reindiginizing the hospital and by extension promoting decolonization. Importantly, having an environment that reflects the strengths of the community and whenua of Hokianga reinforces how special the area is, for locals and IMGs.

The awareness of the need for a change in thinking regarding how local Māori health is approached is evident across Hauora Hokianga. According to Agnes, decolonization is a concept that is discussed regularly with patients and during informal conversations with colleagues:

> *Colonisation is part of the daily conversation here in a way that, I mean, my family at home does social justice work, and that's something that's being talked about all the time in a very intellectual group of people, not necessarily just as normal everyday street conversation. Whereas every one of my Māori patients is talking about decolonizing medicine and decolonizing… It is just a normal part of the conversation. And that's so cool. (Agnes)*

Having an awareness of decolonization potentially highlights a way of thinking about health that wasn't as present in previous generations. However, being aware of the need for decolonization and knowing how to achieve that are distinct aspects of the same solution. During these discussions with patients Agnes noted the link between grandparents being proud of their grandchildren learning te reo Māori and decolonization. In the next section, the ways in which reconnection is being produced in The Pou Kara Ariki will be examined, along with how this reconnection interacts with IMG orientation.

Reconnection

If colonisation is fundamentally about loss, then decolonization is about reconnecting or refinding (Kingi, Russell & Ashby, 2017). Durie (1999) lays out the dimensions of Māori health promotion by utilising the constellation Te Pae Mahutonga to put forward four foundations of health: "cultural identity and access to the Māori world (Mauriora), environmental protection (Waiora), well-being and healthy lifestyles (Toiora), and full participation in wider society (Whaiora)" (cited in Durie, 2003, p. 182). Providing a space where the community of the Hokianga can reengage with these concepts as a health promotion strategy, is integral to the function of the hospital marae. Hauora Hokianga is implementing this reconnection through different practices that link in with patient's identities as Iwi Māori of Hokianga. Hāre utilizes metaphor to explain of reconnection can now how happen in the open and is supported by a historical change in attitudes to tikanga and te reo Māori:

> *"We are in recovery mode and there's so much great knowledge that has been taken from out of the corners that have hid. I went to wānanga 20 years ago, we just did it at nighttime. Now you can do it in daytime now you can do it in the*

daytime. Now you can put certain books over here and over and translate them and get them forward before there's a direct process. This time of the day, this time of the week, this time of the day. And to this certain amount of people now it has been lifted up... So that knowledge is passed on there." (Hāre)

Reconnecting with Mauriora, a sense of cultural identity, is viewed as a work in progress, due in part, to changing attitudes and a tangible sense of pride in being indigenous (Barnes, Gunn, Barnes, Muriwai, Wetherell & McCreanor, 2017). However, while an increased access to traditional ways-of-being are an important first step in empowering the local Māori community, the challenges in transmitting that knowledge are still present after decades of cultural disruption (King, 2019). The extent of the disconnection is such, that building local wellbeing involves re-educating local iwi in older ways of doing things, particularly involving specific roles in the community.

"It's something that each marae is going to on a daily basis nē [right?] *on a weekly basis, yet 30, 40 years ago there's no need for it because a lot of the understanding was there was in every single whānau…But that has all been only certain whānau back home are able to conduct being a minister, being a* kaikaranga [female caller(s) at the beginning of a pōwhiri]*, being a kaimihimihi* [formal speaker]*, being a nehu* [burial attendant], *someone who can do wānanga* [knowledge of local customs]*, because we are not saying it's all decolonization. What we are saying is what people need to wake up, it's in your hands, it's in your hands now. It's still here, it's still there. It's still inside you nē." (Hāre)*

The lack of whānau able to carry out these traditional roles is seen as being partly generational in nature. Hāre views a gap in connection and knowledge between his own era that learned from their whānau, to the generation raised in kōhanga reo (pre-school language 'nests') and kura Kaupapa (Māori full immersion schools). However, the belief that these roles were difficult to fulfil for certain generations who may be cut off from this culture-specific knowledge did not mean that whānau couldn't return to reconnecting with our culture. The concept of the kāinga as an area of settlement was invoked by Hāre to explain the interconnectedness of all local Iwi through whakapapa and the land.

"So, it is about the kāinga as (sic) a place where the regional fires were burned. They were burned for a purpose for succession, for next generation so on and so forth. So are we still connected to those concepts there and those concepts when you take your pepeha, you said your kaputī. That's all part of that kāinga concept

of making connections of saying, I see you, I know who you are. You and I are one because we've met before in the past… How do you be together? And all of that is expressed through you go any these marae is here and your own marae. And it's all expressed, it's all there."

Currently, Hauora Hokianga is providing a number of services that extend the access of Māori health into Hokianga. These services can be viewed as part of the decolonizing process where traditional ways-of-being are reincorporated into day-to-day life in a way that empowers local Māori. The desire for more of these services has been present in Māori communities for decades (Cram, Smith & Johnstone, 2003) but are rarely seen across the country. Since opening the clinics offering traditional ways of healing have been well supported and continue to grow:

"So, the girls able to go mobile for two days and then two days here or we just alternate because there was a big need through our communities with needing to access Taumata Rongoa services, which of course is more than just mirimiri and Rongoa balms. And it just means so much more." (Manaia)

Part of the strength of these collective services is in providing an alternative to Western conceptualisations of illness and presenting empowering concepts of health. The Taumata Rongoa clinics provide traditional Māori health practices for local Iwi and Kopu Wānanga provides support for whānau during their pregnancy journeys (Hauora Hokianga, 2023). Te Pou Kara Ariki has also been collaborating with Pakanae Marae in a programme called Te Kapehu, that provides a cultural healing pathway for those looking to withdraw from methamphetamine or other addictions. Hāre makes the distinction between the indigenous ownership of these concepts in contrast with Pakēhā definitions:

"It is about change for me, the hospital space in the space of wellbeing, not as the space of sickness come to the hospital. So, when we come to the hospital, what signs do you see beforehand? Oh, I see wellness, I hear the birds. I see, I see the flowers I see our Rongoa at the mouth, I when touch, touch. And that's part of Rongoa in the state of balance. Rongoa has been translated by the Pākehā. It's just this and this and this. No, it's not. It's in a state of true balance, which means highest consciousness as possible." (Hāre)

The idea of balance is encapsulated in the interconnectedness of the marae space that incorporates, clinical space, the wharekai (dining hall) and the gardens as an example of holistic approaches to health. The practice of rongoa embodies Māori worldviews as it acknowledges

elements of wairua (spirituality), hinengaro (psychological wellbeing), tinana (physical wellbeing) and whānau or whanaungatanga (connecting the community) through the growing of plants, production of remedies and use of mirimiri (massage) (Mark, Chamberlain & Boulton, 2017). A walkway called Ara Rongoa Whakaora has been created linking the marae and the garden which "provides Korari [flax] for raranga/weaving, Rongoa rakau for medicine, organic food source to be shared between the hospital and community" (Hauora Hokianga, Taumata Rongoa Section, 2023, para. 6). In many ways the Taumata Rongoa epitomises the potential of hospital environments to provide indigenous hubs of wellbeing that address historical cultural disconnection. Manaia reemphasised the necessity of cohesive connections within the hospital itself and also with the wider Hokianga kāinga:

> *"…It's all about us trying to reconnect now, strengthen our connection internally and with the outreach, but with our outreach of our clinics. It's been such a beautiful response. The whānau are really appreciating it because a lot of them have to travel almost at hour plus just to get here" (Manaia).*

There is a distinction to made between acknowledging the macro causes of inequitable health outcomes for Māori (e.g. colonisation) and still needing access to Western medical treatments. While local Iwi having access to rongoa is important in promoting wellness on our terms, there is also an acknowledgment of the place that Western medical approaches have in treatment of acute and chronic disease. This idea may invoke the vital work carried out by Pomare, Buck and Ngata, who applied Western treatments to Western diseases (Laing, 2001). For example, the marae is looking to fund VR software in an attempt to improve health literacy amongst patients:

> *"So, our people come in and let's say I have, because I have diabetes, so put some goggles on or whatever. I can see the state of what someone within my state, I can see exactly where the bloods go. So, we want to give, again, being able to give the power to the people, not the power held by certain people there so people can experience. So, if you're going to smoke, put these goggles on. This is what's happened to your smoking to the body... So, you are smoking now your kids are smoking. So, what are we doing?" (Hāre)*

Improving education about Western health approaches for local Māori can be viewed as an attempt to readdress power imbalances caused through a knowledge gap, in a safe environment where different worldviews can be drawn upon to build a deeper holistic understanding of hauora. Having an approach that embraces traditional ways-of-wellbeing while acknowledging the need for Western treatments, could provide an optimal platform from which to teach

kaimahi about the needs of the community. This decolonized space provides the foundation from which orientation programmes for staff and university medical students (ākonga) can be taught about Māori culture in Hokianga. The last section of this analysis will concentrate on how Hauora Hokianga is working to educate its staff and how that is perceived by the IMGs who are taking part.

Cultural Safety Training and Te Takapau Wānanga

The specific historical, social and cultural environment that has shaped the Iwi of the Hokianga demands an orientation programme that encourages nuanced understandings that are located in the kāinga. Local Iwi empowerment through strength-based health initiatives like Taumata Rongoa may build resilience in the community (Durie, 1999), but it is also important that medical staff are given the opportunity to increase their understanding of local customs. As previously discussed, cultural safety courses are inconsistently applied across the country, with weak guidelines and resources available to implement comprehensive training for IMGs. The resources that are available, such as the NZ Locums 3-day course are brief and understandably universalistic in approach. This has left some IMGs in rural Māori communities feeling underprepared when they begin consultations. Agnes was surprised by how little guidance on local Māori practices was provided when she started her first medical job in the Far North:

> *"They just threw me in with this 80% Māori patient population, but no cultural background whatsoever. Nothing. I'm just taking care of them. Great. I know how to do medicine, but I don't know anything about how they're thinking or whatever." (Agnes)*

Although, as previously analysed, developing better understandings about tikanga Māori may not be a priority in the face of other professional needs, the desire for IMGs to know more about the indigenous population was commonly felt. While not all doctors will feel like this and the mantra of 'I treat every patient the same, regardless of race' rhetoric still survives (Goodyear-Smith & Ashton, 2019), the expressions of unpreparedness by IMGs is instructive. Having confidence in your ability to connect with patients and build trust through cultural awareness should be fundamental to practicing patient (or whānau) centred approaches (Kirmayer, Bennegadi & Kastrup, 2017). Within the last year Hauora Hokianga has begun to implement a cultural education programme that is primarily aimed at educating medical students, but also caters for staff, including new IMGs.

The Course

Te Takapau Wānanga is a programme that runs in conjunction with the University of Auckland that provides education on Rural health, Hauora Māori and interprofessional education (Hauora Hokianga, 2023). The course is open to students across different health pathways and happens along-side clinical patients at Hauora Hokianga. The students (ākonga) participate in noho, where they eat, learn and sleep at the marae as part of the experience. Since 2023 it has become mandatory for Hokianga Hauora staff (kaimahi) to attend the 4 weekly sessions of the 5-week course:

> *"They're who are able to enhance our cultural awareness. So, we're hoping by the end of, so it's a two-year pilot programme and we're hoping by the end of next year we'll be able to get all of our Kai Mahi through" (Manaia)*

The content of the courses covers the full spectrum of Māori health interactions from a Māori perspective, attempting to shed light on the interaction of indigenous peoples in Western medical settings. The curriculum for the Wānanga covers fundamental concepts in Hauora Māori and rural health, while also providing information and learning that is specific to Hokianga Hauora. These concepts may be broad illustrations of Mātauranga Māori, like demonstrating manaakitanga in professional settings, or contextual historical learning regarding Tino Rangatiratanga and Colonization. The programme also incorporates the interaction of Māori culture and medical fields such as Palliative Care or Mental Health in order to highlight the differences in world view that may affect treatment. Potentially the most pertinent aspect of this programme, however, is the specificity of the Hokianga in the curriculum. Agnes discussed the importance of learning this localised curriculum to her practice in the Hokianga:

> "*…They gave me four full days of Māori cultural education here…So to do that was just beautiful. So, they did, and I mean, they paid me my full salary to do it on those days. So that was a huge benefit to me. So, it was over four weeks. I did two days and then one day and then one day each. And so, it was spread out. But yeah, it was great. I mean, I just sat in with the med students. It's the same thing they're doing for the rural track med students right now. And I spent the night at the marae, all kinds of waiata and music and all kinds of stuff. It was really fun. Lots of lecturers coming in." (Agnes)*

The specific cultural awareness course for staff is called Takapau Taonga and is led by Te Taumata o Hauora Hokianga, or cultural advisors of Hokianga. The courses take place at local marae, such as Pakanae and cover knowledge and topics that are relevant to Hokianga. The location is

relevant in that theoretical learning is constantly reinforced via experiencing the practices on the marae. Within a learning block, for example, participants learn about a marae-based solutions to meth and addictions, as well as the importance of whakapapa to the treatment process. The Taumata are able to present a holistic approach to hauora by bringing in the different strands of local Māori experience, inside a space which is a repository for that knowledge. Guest speakers and instructors are brought in from the local community and further abroad via zoom, to offer insights into practices that shape Māori health. Speakers discuss gathering kai, for example, and how that demonstrates the interaction between whānau, the land and health. Historical accounts are given of the area to illustrate how wider events and trends have created the modern Hokianga environment. This understanding helped Agnes to place her patients in a wider cultural context:

> *"No, it was everything. I mean, we went and did the tour over at Omania. As part of it. Yeah. So, we got the whole history and I mean, yeah, that was just talked about a lot. I mean, here we are in the Hokianga, and I had this realisation at (her last practice). My patients were always expressed in a very, very intentional way, whereas maybe the European patients would just be like, oh, thanks Doc. And walk out the door. My Māori patients would sit and say, doctor, I really appreciate your time. Thank you for taking care of me today. Thank you for whatever. And before they walked out the door and it was different. It was really different. And I realised as I went through that cultural programme that is very much just deeply embedded in the culture, and that was really beautiful." (Agnes)*

From the perspectives of physicians practicing Western medicine, there are advantages to being able to establish links between patients and their cultural contexts (Kaba & Sooriakumaran, 2007). Part of developing these relationships is recognising how the day-to-day behaviour of patients is embedded in their cultural identities, that positions the person in a specific place and time (Kitayama & Park, 2017). Agnes making the link between the cultural values explained at the marae and then noticing how it is reproduced via the behaviour she notices in consultations is an example of this synthesis. This concept is reiterated by Hāre explaining how connection occurs through the marae as a location for experiential learning:

> *"And you have tika, pono, aroha, you have tapu, you have mana you have noa, you have wairuatanga, you have whakapapatanga you have korero tawhito, karakia tawhito, you have wānanga – you have all of those aspects that we can drill into to strengthen those connections nē. And that's what each client does on a weekly*

basis. When they have hui. A Hui is, when a marae opens, how we're talking in this present moment, a hui a wānanga, is you are transporting yourself into the past to the old pa sites to the old papa kāinga site nē. So, all of these words, all of their power, all of their empowerment is there on the marae." (Hāre)

The universalistic application of Western health practice across different cultures, irrespective of cultural location, can lead to misunderstandings about health behaviours (M Kagawa-Singer, S Kassim-Lakha, 2003). Having a better idea of what the whole person may look like, due to understanding these contextual factors, could potentially improve how doctors view their patients help seeking behaviours or compliance. Providing equitable care depends in part on understanding these socio-cultural contexts. Attempting to understand these different cultural perspectives can take a certain amount of reflexivity that involves thinking about your own culture as much as other cultures.

The approach: Wairuatanga

Cultural education is hindered by environments that conflicted (Pecukonis, Doyle & Bliss, 2008). The weight of the history of indigeneity may sit on cultural education programmes in New Zealand, and the need for safe, welcoming settings is potentially important. The ethos that informs teaching at Te Takapau Wānanga may be founded on localised indigenous principals, but it also displays humanistic qualities that encourage participation and reflection in a safe environment. As Hāre explains:

"So, we all within the same pathway or within the same elements that we all just connected as such and express, what does that mean there? So, if we understand this and we feel this and we know this, so how do we express this knowing in our voices, our actions nē and what we do?" (Hāre)

These principals emphasise the similarities rather than the differences between people and cultures. Listening to and reflecting on these similarities through discussions around the importance of karakia (incantations or ritual chanting) reinforces the concept of reconnecting with ancestors, the land and spirituality (Ritchie & Rau, 2010). Reconnecting with who you are through the acknowledgement of one's ancestors or culture is an important part of this process. By highlighting the similarities in experiences of the ākonga or kaimahi, Hāre puts forward a humanistic worldview where connections with your own whakapapa, irrespective of culture are a unifying spiritual force:

> *"When we have our marae stay, we talk about what is human and what predicts a human. There's a male element, there's a female element nē and who was the creator of these elements? And within our dialogues within, and it has come through all of which we know that everyone, no matter what religion or what people they come from, there are similarities, more similarities than differences there." (Hāre)*

Engaging in some aspects of spirituality may also encourage looking at health and wellbeing through a holistic lens that is closer to local conceptualisations of health (Came et al., 2020). Wairuatanga in this sense is not prescriptive, often emphasises how people are interacting with their environment and might transcend purely indigenous understandings (Valentine, Tassell-Mataamua & Flett, 2017). The concept of ties between local Iwi and the land are potentially reinforced by giving new staff an opportunity to experience the environment and those ties themselves. These connections with the land are difficult to make theoretically and experiencing the locations that shape the way people are, is difficult to do online or in another part of the country. The importance of experiencing the environment first hand is built upon by Hāre:

> *"You go to the cemetery, you feel the same, you go and walk your mountains or go to your spring…all of those connections are there nē, enhancing people there. And how do we capture that? Not how we capture, but that's how to express that to new workers coming, based from overseas, those who are from other of Aotearoa as such." (Hāre)*

The ties to the land are made through sharing and acknowledging the stories that are interwoven between the Iwi and the land (Valentine et al., 2017). The specialness of the 'centre of the universe' and the inherent strengths that lie here. This understanding of Hokianga as a kāinga or settlement, that is connected through whakapapa and shared experiences is a key concept that underpins the wānanga. Manaia sums up the key role of the marae noho (marae stay) to experiential learning and the importance of IMGs connecting to tikanga Māori in an inclusive environment:

> *"And I think that too is one of the importance of having the Takapau Wānanga component so that our kaimahi is still able to still learn alongside our new tauira as well or students or student doctors or, I just think it's so important and they're able to just not read about it, but they're actually able to live it. So, they can come and experience it. Live in marae noho and life the reality of reality and being able to stay the night and listen... and reconnect and reindigenize themselves in their*

own. It's not just for Māori, but it's about reawakening all their senses for them so that they're able to connect with themselves and their own culture. Just that Māori and our tikanga practises are kind of just the, it's just almost just a guideline for them, A safe space, safe pathway for them to be able to reconnect. And then that's when they get to just as matua says, touch base on the different realms like the hinengaro the wairua, but they're able to actually live it, breathe it, see it and connect whether it's wairua, whether it's physically, and just taking off your shoes and reconnecting, grounding yourselves again. So, I think that's such an important aspect of Takapau Taonga." (Manaia)

New Zealand's health policy has often looked to conglomerate Māori health into one homogenous mass (Kukutai, 2004) that remains static and caught in a never-ending spiral of negative health statistics (Ryks, Simmonds & Whitehead, 2019). What these universalistic policy approaches fail to grasp is the uniqueness, resilience and strength that different communities contain. The idea of Hokianga as a settlement where challenges and successes are specific to the kāinga is a concept that is not often embraced in national health policies. IMGs are not given much in the way of cultural awareness support on arriving in New Zealand and what they are provided with information and support that offers little insight into Māori ways-of-being. The interaction between the marae, kaumatua and health governance in Hokianga, has provided an example of how communities can be empowered to utilise existing strengths to improve upon current orientation programmes.

Chapter Five: Discussion

Health care that is responsive to the cultural needs of its rural Māori patients, needs to be informed by the distinctive environments that shape our communities (Kearns, 1991; Hond, Ratima & Edwards, 2019). This thesis moves away from top-down approaches to IMG orientation to relocate cultural education into the communities where they will work. For Māori, that may traditionally mean the rohe of our Iwi or the urban environment that shapes our sense of who we are (Durie, 1994). Often for Māori, the marae, awa and maunga specifically shape how the world is understood and by extension how health is experienced (Moewaka-Barnes & McCreanor, 2019). The need for cultural training that reflects these specific locations is vital in closing the gap in health outcomes for rural Māori (Eggleton, 2020). Current practice for doctor education is informed by a generally broad understanding of Māori culture (MCNZ, 2011). Cultural competency training provides a platform from which universalistic skills can be acquired, but often fails to address broader causal concerns that underlie inequity, like coloniality (Pon, 2009). Cultural Safety programmes challenge students to question their biases through reflexivity, thereby addressing some of the ongoing drivers of colonisation (Wepa, 2015). Hauora Māori training provides specific Māori health models as theoretical exemplars from which to practice from (Jones, Pitama, Huria, Poole, McKimm, Pinnock & Reid, 2010). In theory, the coverage of topics around Māori health seems thorough. However, neither outcomes nor attitudes towards doctor-patient interactions seem to be improving from a Māori consumer perspective (Cormack, Stanley & Harris, 2018), thereby raising questions about the application of theory to real world situations. While outside the scope of this study, the application of cultural education programmes across and within regions is inconsistent and possibly viewed by some practices as a further burden onto their bureaucratic load. This unevenness may then place a further burden on the relatively unregulated cultural education of International Medical Graduates as they arrive in practices that aren't meeting the needs of their Māori population.

The relationship between many Māori and New Zealand health services has been defined by Western ideas of illness (Durie, 1985). This process has led to an environment where mechanistic and individualised 'illness' has forcibly replaced interconnected, collective wellbeing, that incorporates the body, with the mind, the family, spirituality and the physical environment (Panelli & Tipa, 2007). After a political process that has occasionally offered Māori

autonomy over our health, but has more often encouraged cultural assimilation, there is a movement towards reconnection with traditional practices, to improve collective wellbeing (Durie, 2005; Reid, Cormack & Paine, 2019). International Medical Graduates are arriving at a time when they are needed, as staff shortages are a pressing concern for many practices across the country (Andrew, 2024). They are also working in rural Māori communities that are trying to reconnect with traditional ideas of health, as part of a process of decolonization (Mark, Chamberlain & Boulton, 2017). These locations however have their own specific needs and practices that are dictated by the Iwi and hapu of the rohe (Mutu, 2020). The local marae epitomises these specific traditions and practices (Mead, 2016). Empowering these traditional sites of community strength, to educate IMGs about culturally appropriate practices might provide a more suitable location physically, spiritually and theoretically than current universalistic ideas of Māori health taught in Wellington. Local Iwi of the Hokianga and Hauora Hokianga are initiating an inclusive programme that incorporates both indigenous and Western worldviews in a way that may promote a higher level of satisfaction for local Māori.

International Medical Graduates are a core part of the rural New Zealand medical workforce and provide an invaluable service to regions that are often avoided by New Zealand trained doctors (Lawrenson, Reid, Nixon & Laurenson, 2016). The MCNZ (2011) provide guidelines that are low on detail and place the ultimate responsibility for the cultural orientation of IMGs at the feet of rural practices. The New Zealand Rural General Practice Network (Hauora Taiwhenua) (2024) provides some support for rural practices by providing a one-week orientation programme that covers a wide range of pertinent topics and ensures that registration occurs smoothly. Indigenous health is a small part of an extensive range of content that they cover. This limited coverage is exacerbated by the state of indigenous health education globally (Hardy, Filipenko, Smylie, Ziegler & Smylie, 2023). Indigenous education programmes seem to be underdeveloped in OECD countries leading to a situation where many IMGs have little exposure to the unique challenges facing indigenous populations. This is then compounded by a paucity of education (often due to time and financial constraints) after arrival in New Zealand. This may explain the broadness of the cultural education for IMGs on arriving in New Zealand, as often the knowledge of indigenous health or more specifically Māori health is underdeveloped.

There is significant demand for IMGs globally to fill high need areas, such as isolated or socially deprived locations. Within colonised countries, there is often an over representation of

indigenous peoples in these underserved regions (Marrone, 2007). Considering the scale of these medical migrations across the developing and developed world, the lack of literature on IMG acculturation stress and orientation into rural communities is surprising. Both rural and indigenous communities have their own unique health behaviours that differ from universalistic applications of medicine (Durey, Hill, Arkles, Gilles, Peterson, Wearne, Canuto & Pulver, 2008). There is a paucity of examples of training schemes that focus on the education of IMGs into new non-monoculturalistic settings. A great deal of literature concentrates purely on the necessity of IMGs to assimilate into the host countries monoculture (Morrow, Rothwell, Burford & Illing, 2013; Michalski, Farhan, Motschall, Vach, Boeker, 2017). This trend elicits questions of what constitutes healthy acculturation for IMGs and the rural indigenous populations that they are working with? Immigration is difficult and healthy acculturation can involve overcoming numerous barriers including language, cultural norms and the resettlement of families (Sam & Berry, 2010). If IMGs are not given the tools to interact with indigenous cultures on their terms, then there is an assumption that mainstream culture acts as the only pathway to communication. In not providing the necessary cultural education for IMGs, are health departments assuming that both IMGs and indigenous cultures will both assimilate fully into mainstream culture? In New Zealand, the MCNZ has outsourced this task to a third party and in doing so has abdicated responsibility for the process. There seems little oversight or provision from the New Zealand Ministry of Health in addressing the inconsistency of culturally responsive medical training for IMGs either.

A relationship between Iwi and the Crown whereby support is nominally given, but undercut by material resources, is a consistent theme in the history of New Zealand government health policy. The moving away from openly assimilationist policies occurred in New Zealand during the Kirk Labour government 1972-74 but gains by Māori to wrest real-terms control from the government, have been mixed at best (Brown & Bryder, 2023). Prior to the Māori renaissance of the 1970's, Iwi had tried to adjust to various population health risks with the limited resources that were available. The rapid decline of the Māori population post European settlement was addressed via the Western medical training and dedication of Māori health experts. The recognition of Māori efforts on both World Wars allowed Iwi councils to improve living conditions with limited resources, whilst fending off consistent government attempts to undermine their successes (Hill, 2009). Both Te Rōpu ō Te Ora (The Women's Health League) and the Women's Health League addressed pressing health issues for Māori, such as high maternal and infant mortality rates by developing grass roots approaches that utilised inherent strengths

in Māori communities. These initiatives were often coopted by the New Zealand government over time as a way to exert control over the direction of Māori health (Hill, 2012).

The 'Epidemiological Era' whereby the downstream effects of colonisation created a health environment for Māori that couldn't be fixed by individualised health interventions, like vaccinations, has become the preeminent challenge for health experts today (Hill, 2009). Poor living conditions exacerbated by multi-generational loss and disenfranchisement has led to gross inequality. Assimilating into Pākehā culture on unequal foundations has underlined the need for Tino Rangatiratanga or Māori control over decisions that affect Māori (Wihongi, 2010). This control has been difficult to actualise. Biculturalism has become entrenched in New Zealand society via the legislative influence of the Waitangi Tribunal. However, the lack of continuity across competing governments and perhaps more importantly, economic approaches, has created a graveyard of Māori health policies (Brown & Bryder, 2023). From neo-liberalism to the promise of He Korowai Oranga, there has been an underlying feeling that New Zealand Health policy for the indigenous population is driven by Western health approaches while motifs of actual Māori conceptualisations are used as window dressing.

The cycle of assimilationist health policies that have oscillated between paternalistic oversight and under resourced devolution fundamentally failed to embrace the existing strengths of traditional Māori approaches to health. The historically similar levels of hygiene witnessed during initial contact between Māori Iwi and Pakēhā reinforces these inherent strengths that stemmed from maintaining collective wellbeing through a mix of spirituality and pragmatism (Durie, 1994). The use of tohunga to dynamically interpret and enforce tapu as health promotion illustrates a preexisting health system that could have been utilised (Durie, 1999). There were also (and continue to be) similarities in traditional Māori and Western approaches to physical health and a willingness from Māori health leaders to embrace aspects of Western health approaches. The failure of the New Zealand government has been the unwillingness to incorporate ideas of health that fall outside of these similarities, while also failing to address the ongoing distal effects of colonisation.

Globally, many indigenous health advocates have attempted to promote solidarity amongst colonised peoples in an attempt to highlight the inequity of health experiences between settler

populations and indigenous peoples (Niezen, 2000). Broad similarities in holism and collectivist societal structures are furthered by the common feelings of loss experienced in the face of colonialism (Berkes & Berkes, 2009). The loss of access to traditional land and the related resources, both spiritual and material, is often at the centre of these experiences. Researchers have placed coloniality as a distal determinant of inequitable health outcomes for indigenous peoples based on, historical deprivation leading to contemporary disadvantage (Czyzewski, 2011). This disadvantage is often indistinguishable from the "the non-medical factors that influence health outcomes" (WHO, 2024, Social Determinants of Health, para. 3), known as the social determinants of health. The inequitable distribution of social, political and economic resources plays a critical role in the maintenance of the gap in health outcomes for indigenous peoples. In the face of this inequity, indigenous peoples have tried to improve health outcomes by reconnecting with traditional ways of to break from Western models of health that might be reinforcing, maintaining or even framing these negative health statistics.

The last 50 years have seen attempts by health researchers to offer health models that reflect a more contextualised perspective to individual health (*c.f.* Lehman & David, 2017). The biopsychosocial model places how individuals experience health at the middle of broader environmental factors (Engel, 1977). The conception of this model can be viewed as a direct critique of biomedicine, as it looked to readdress the methodological reductionism inherent to 20th century medical practice. In theory, biopsychosocial models are a step closer to embracing different experiences of health, including diverse cultural realities, but in practice, attempts to operationalize the theory have uncovered an underdeveloped conceptualisation of health that is still fundamentally biomedical in nature (Ogden, 1997).

Driven by wave after wave of technological advances and a multibillion-dollar industry, biomedicine remains the most dominant theoretical approach in modern healthcare (Lock & Nguyen, 2018). Considered by Davis-Floyd and St John (1997) as a technocratic model of medicine promotes a linear conceptualisation of progress that is driven by technological advancements. However, for many cultures, including Māori, the body does not function independently of the way that we experience the world. Indigenous populations, separated from their land and ways of being, can be biologically 'well' without feeling a sense of wellness. Reducing the human experience of wellness to a cycle of attending to and fixing broken parts without acknowledging the importance of relationships, has proven to be an approach that is

not working for Indigenous populations (Lutschini, 2005; Cram, McCreanor, Smith, Nairn & Johnstone, 2006; Martin, 2012). These conceptualisations of health are not necessarily incompatible. If the positivistic theoretical roots of biomedicine and the attendant colonising baggage can be separated from treatment, there is room available under a broader idea of indigenous wellbeing that empowers different cultural realities, addresses past and ongoing inequity while utilising the advantages of modern medicine.

At the core of these health care approaches is how our cultural identities shape our conceptualisations of health. That methods for addressing how we experience feeling unwell often reflect our cultures is unsurprising, as these theories are forged through our ideas of life, death and purpose over time (Kirmayer, 2005). It thereby seems obvious that applying methods of care that reflect a completely different paradigm onto other cultures will not necessarily produce the desired results. Biomedical theory was forged in the specific Western European contexts of the Enlightenment, the Industrial Revolution, Imperialism, and the aftermath of two World Wars (Lock & Nguyen, 2018). These locations do not reflect the historical experiences of other cultures and create a level of disconnection when they are applied to other peoples. Ultimately, it is the disconnection between these different world views that need to be reconciled in IMG orientation.

Key Findings

The key findings of this research focus on how IMGs are currently being supported professionally to meet the needs of rural Māori communities. They also look to how orientation programmes, alongside proper financial support, can create an environment where international doctors are more likely to put down roots in these communities, thereby developing long term community buy in. The opportunity for IMGs to be part of a movement towards reconnection within rural Māori communities by participating in aspects of local tikanga, such as pōwhiri, can aid in building these relationships. An increased appetite for decolonisation in health provision through reconnection is being guided by marae in some rural Māori communities. Marae have the potential to act as a hub for the culturally safe interaction of Western and local Māori health practices that may provide an excellent foundation from which IMGs can experience local tikanga. The last finding highlights Te Takapau Wānanga as an example of the possible synergy that can be harnessed between the various stakeholders in the Hokianga as a way forward for Indigenous health in the wider region.

International Medical Graduates are Feeling Underprepared for Rural NZ Communities.

Current national policies for IMG orientation are not meeting the needs of rural Māori or IMGs. The quality of the current pathway for IMG orientation is leaving many participants feeling underprepared for meeting the needs of rural Māori communities. The brevity of the national orientation experience and the subsequent lack of detail on all aspects of New Zealand life and practice places sever limitations on the equality of Māori health education. There are a number of factors involved in this perceived shortcoming that are placing pressure on the delivery of a more comprehensive service. A shortage of GPs nationally, has an outsized effect on rural recruitment and retention. This in turn is creating an understaffed workforce and an under resourced patient population leading to the need for new doctors to start immediately. This time pressure is experienced acutely by IMGs who are also trying to acculturate to new social and professional environments. However, this factor may only provide part of the problem. Whilst recruitment has often been an issue for rural New Zealand practices, the length or quality of orientation programmes doesn't seem to be affected by demand historically. It is possible that IMG orientation is just a low priority, particularly regarding the nuances of Māori health provision. There was a feeling amongst some participants that there is a 'box-ticking' element to IMG cultural orientation nationally. This may leave both parties interactions being mediated through the prevailing monoculture. This makes sense considering the historical emphasis on assimilation in Māori health and the biomedical nature of the qualifications needed to practice. The importance of relationship building in medical consultations is vital to the quality of care and uncertainty around the correct way to interact with Māori patients may undermine future treatment.

Improving Orientation and Renumeration Will Encourage Community Buy In.

IMG orientation needs to be improved along with renumeration packages to increase the chances of rural retention. The high turnover of doctors in rural Northland can lead to a weariness from the local Māori community that undermines the development of doctor-patient trust. Currently, there are a number of factors that are contributing to low doctor retention rates, including acculturation stress, poor renumeration and an under resourced environment that makes it difficult for international doctors to raise families in. Orientation programmes that allow time for immigrants to overcome acculturation stressors like understanding the software programmes, or more pertinently, understanding the cultures of their patients should improve

the initial settlement period. Long term, the difficulties of living remotely such as limited options in childcare and activities needs to be accounted for through more financial incentivisation. These recommendations can be used to support the inherent strengths of these communities. Participants reiterated the many aspects of living in rural Northland that they loved and often these strengths were in contrast to the social or political environments in their home nations. Push factors such as the inequitable nature of the U.S health system, were viewed as reasons to stay within the rohe.

The importance of trust in historically marginalised communities cannot be understated. Consultation, honesty and the adherence to a mutually understood pathway to treatment hinges on this trust. While the turnover of staff is expected in any industry in any location, the effects of low retention in isolated predominantly Māori locations can erode trust in doctor-patient interactions. The concept of kanohi kitea, or the 'seen face' exemplifies the building of trust by new IMGs, via consistency and presence within a community over time. Within the Hokianga, there is the potential for a high level of buy in as the participants, in the face of some barriers, have an affinity to the people and a willingness to serve the community. Changes to structural factors such as policies encouraging slower and more detailed orientation may bolster these existing strengths.

Cultural Reconnection Should be Central to IMG Cultural Orientation Programmes.

The desire for reconnection in rural Māori communities should be folded into IMG orientation programmes in order to break the cyclical reenactment of settler-colonized relationships in health provision. Discussions about decolonization were common in the community and experienced by both doctors and patients. There was tangible pride expressed from older generations of local Māori about the reconnection of their mokopuna (grandchildren) with traditional ways of being. This reconnection was stated in contrast to their own experiences of dislocation and held up as a way forward for the community. Local Iwi leadership additionally views the ability to enact these traditional ways of being as something that was lost that is now being transferred and reestablished via the youth. Rebuilding the practice of tikanga as a foundation for community hauora, provides a platform from which these localised practices can be shared with incoming IMGs. Most IMGs are arriving in rural medical practices with a broad and sometimes limited knowledge of Māori culture that does not prepare them for the realities of those communities. Opportunities to both greet and express these realities are viewed as

helping to narrow the gap in knowledge and experience for IMGs. The IMGs who experienced formalised greetings in the form of pōwhiri for example, felt that they had been welcomed into the community and understood more about the culture. These interactions allow both parties to express who they are and find common cause through reconnections with their histories. For local Iwi it is an opportunity to display the specific ways of our community, including manaakitanga, while reasserting the distinctness of our culture within the health system. For IMGs it is a chance to share experiences and build relationships with members of the community that they will be serving.

Context Specific Kaupapa Māori Research?

During a phase of methodological reflection, I was surprised by how my understanding of Kaupapa Māori had altered over the course of the research, from a fixed idea of Te Ao Māori to something more nuanced. When Hāre discussed tikanga and rangatiratanga he wasn't just referring to a classical settler-colonialist paradigm, but to other Iwi (and other non Hokianga hapu). In part, this signals a rejection of the concept of Te Ao Māori when it intersects with the authority of the Hokianga Iwi. While some localised idea of autonomy was expected, the intensity of the line between what was tika and what wasn't was unanticipated and made me rethink my approach to Kaupapa Māori research. The research journey from Te Ao Māori framing to a more localised tikanga, raises questions around Kaupapa Māori applications in isolated rural communities. It is outside of my expertise or authority to define what demarcates the features of these differences, but future research could investigate the application of Kaupapa Māori agendas across different locations and tribal contexts. With more support, the concept of Kaupapa Hokianga research might have been a more appropriate methodological position.

Localised Practices Should Inform IMG Orientation.

Orientating IMGs into rural Māori communities needs to be localised and based on local knowledge rather than universalised conceptualisations of Māori culture. This is in keeping with the attitudes of members of the local community who view themselves as Ngāpuhi, Te Roraoa or Te Rarawa rather than Māori. To some, ideas of encouraging broad concepts of Māoridom on local health promotion is an attack on tino rangatiratanga or self-determination. For local Iwi, 'Māori' health promotion is non-representative of their worldviews and is more the extension of the colonising discourse. An argument can be made for orientation programmes beginning with

a generalised content that embraces a wider idea of Māori culture as many IMGs have some knowledge of New Zealand but may know nothing of its indigenous culture prior to arriving. There is, however, limits to an orientation approach that relies heavily on a homogenous conceptualisation of Māori, particularly in rural New Zealand communities. Knowledge about the local Māori population should stem from that community themselves. This is both a practical and moral imperative. Practically, learning about the nuances of community with guidelines that don't specifically resonate with that population is inefficient and potentially counter-productive. These rural communities experience specific shared realities that are shaped by historical, social and cultural influences. Morally, the ownership of this specific information belongs to the local Iwi of these communities. If knowing these influences is relevant to improving patient interactions, then the correct information needs to be provided through marae.

Hauora Hokianga is Providing a Practice-Marae Model that could be Replicated.

The Te Takapau Wānanga initiative may provide a model for localised IMG cultural orientation that can be reproduced around Te Tai Tokerau. While acknowledging the unique funding model in place at Hauora Hokianga that is run via community trust, a model that incorporates the amalgamation of marae, education centre and local Māori health practices could provide a pathway for an improvement in overall indigenous health. Rural communities could shape these relationships to suit the specific contexts of their collective experiences, but the use of marae as health hub builds on a preexisting network that epitomises indigenous empowerment. In part, a functioning hospital-based Marae helps to decolonize an environment that is traditionally Western. It provides a space where the Māori community can be comfortable and see representations of our worldviews. This is encouraged further by the promotion and practice of rongoa services that exemplify a coexistence of bicultural treatments within a traditionally colonial space. As an education centre for kaimahi, IMGs and students Te Pou Kara Ariki provides an exemplar for local Māori ways of being by providing a space for pōwhiri. The connection of this marae with other marae in the Hokianga acts as a way to harness the collective strength of the three Iwi of the region. This collective strength is displayed in the structure of Te Takapau Wānanga programmes that utilise local and outside knowledge to explain the specific contexts that the community experiences health and wellbeing within. The interaction of both Western and local Māori conceptualisations of health in a practical setting can act as an exemplar for all stakeholders in indigenous health interactions, including IMGs to work towards. This synchronicity at a sight of traditional colonial practices can be a way forward for rural Māori

health in that it promotes decolonisation through reconnection while acknowledging the necessity of some Western health approaches.

Chapter Six: Conclusion

Reflecting on my first research project, I have been surprised by the amount of autonomy that each practice/organisation is given regarding orientating IMGs on culturally appropriate care. The variation in approaches outside of what is provided by the New Zealand Rural General Practice Network leads to a situation where some rural Māori consumers are getting a higher chance of culturally appropriate care than others. The overall lack of time and resources that are allocated to supporting IMGs from a national perspective presents an environment where cultural considerations are deemphasised in favour of more pressing issues that revolve around staffing and purely medical considerations. The assumption that a medic can be transplanted from one dissimilar cultural context to another without significant support is difficult to understand. Successful medical interactions depend on shared understandings and trust, which is hard to develop without a mutual understanding of cultural practices between patient and doctor. These ideas are echoed in the responses from IMGs who generally feel underprepared to work in rural New Zealand environments with Māori populations.

There are many potential areas of inquiry to investigate within the complex socio-cultural dynamics that occur between the different stakeholders involved in rural Māori- IMG- Medical Practice relationships. I was lucky enough to gain insight into the IMG experience through my stepfather's connections with the medical world and insight into Te Takapau Wānanga through my whakapapa connections. This positioning allowed me to bridge two different spheres and gain some insight into the overall interactions between the State, medical organisations and Iwi. My experience as Māori and as someone married to an IMG aided me in finding contextuality to the patterns in interactions between the different stakeholders. This experience, however, is still limited in some ways by the ability to spend longer with participants and key informants. This is a consequence of not being based in the Hokianga itself as I was limited by what could be achieved after a 3-hour drive. Spending more time around Hauora Hokianga may have allowed me to witness more interactions amongst stakeholders first hand.

The IMGs that I talked to formally and informally had an amazing amount of aroha for their communities and a desire to learn more about tikanga Māori. There were some topics that didn't manifest directly that would further the overall understanding of the topic. Discussions

about colonisation and the distal effects of coloniality were often absent. This was in stark contrast to discussions with Māori participants. Further inquiries about how IMGs understood the colonial history of health in New Zealand and its contemporary relevance would address some questions regarding the content of cultural orientation. There was some discussion about the differences in orientation experience between IMG colleagues amongst participants regarding time frames. The scope of this thesis didn't extend to other regions of New Zealand, but the variance in orientation both across and between regions would shed some light on how deregulated orientation programmes are nationally.

Looking forward, there also needs to be further investigation into what rural Māori want from our health services. There is little research on what constitutes a favourable doctor-patient interaction outside of preferring doctors who identify as Māori. There have been some initiatives recently that aim to increase the percentage of Māori doctors nationally, but realistically non-Māori doctors will always make up the majority of the workforce. New Zealand governments have at different times tried unsuccessfully to address the heavy reliance on IMGs, as is illustrated by the current numbers. This realistic acknowledgment of the GP workforce should encourage a clear plan to orientate international doctors to meet the needs of rural Māori communities. The participants in this study that represent local Iwi of the Hokianga suggest that this orientation needs to be shaped by local knowledge. Further investigation should occur to question whether these opinions are supported by local Māori in the Hokianga and in other rural Māori communities in Te Tai Tokerau Northland. The diversity in Māori worldviews also extends beyond the rural-urban divide and gaining a more complete understanding of this diversity, in terms of preferences in health provision would also improve cultural education programmes for medics.

The progress of Te Takapau Wānanga, Te Pou Kara Ariki and Hauora Hokianga in developing an aspirational health service, could act as a model for other rural medical practices. Some efforts should be made to investigate the viability of using Iwi to participate in and eventually drive IMG orientation. How these changes affect local Māori consumers themselves is still unknown and future research could analyse how this cohort feels about these initiatives. Anecdotally, there is pride in having a health service that reflects the worldview of the community. This sense of pride is vital in improving hauora, as key stakeholders work together to provide a health service

that addresses the lasting effects of colonisation by providing a service that harnesses and represents the inherent strengths of the community.

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Appendix A

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Dear:

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our database for inclusion in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please contact a Research Ethics Administrator.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Dr Brian Finch, Director - Ethics, telephone 06 3569099 ext 86015, email humanethics@massey.ac.nz. "

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Dr Brian Finch Chair, Human Ethics Chairs' Committee and Director (Research Ethics)