



Cultural and clinical practice realities of Māori nurses in Aotearoa New Zealand: The emotional labour of Indigenous nurses

Ngā āhuatanga ahurea, taurima tūrora tūturu hoki mō ngā tapuhi Māori i Aotearoa: Te mahi kare ā-roto a ngā tapuhi iwi taketake

Kiri Hunter MN, DipTLT, RN, Senior Lecturer, Nelson Marlborough Institute of Technology, Nelson, Aotearoa New Zealand; Ngāti Kahungunu, Rangitāne, Ngāti Maniapoto

Catherine Cook PhD, RN, Senior Lecturer, Auckland University of Technology, Auckland, Aotearoa New Zealand

Abstract

In Aotearoa New Zealand there is limited research exploring the tensions for Indigenous Māori nurses when integrating cultural priorities into clinical practice. This study explores how Māori nurses navigate delivering culturally responsive care to iwi, hapū, and Māori whānau across different healthcare settings. A qualitative Indigenous narrative inquiry was used to obtain data. Semi-structured interviews were conducted with 12 Māori registered nurses and nurse practitioners. The thematic analysis was both inductive and deductive. The narratives provide insight into the nurses' holistic Indigenous world view by contextualising their professional practice experiences. Four main themes were derived from data: *te tuakiri Māori - cultural identity*; *kawenga taumaha - bearing the burden*; *te kaikiritanga - racism*; and *tauutuutu - reciprocity*. Māori practitioners routinely experienced compromises within biomedically oriented healthcare services. Practitioners witnessed discriminatory practices that may negatively impact on healthcare outcomes. Sustained cultural dissonance may also negatively impact on retention of Māori nurses. Māori practitioners value tauwi colleagues who work as allies and affirm culturally shaped care for Māori.

Hunter, K., & Cook, C.M. (2020). Cultural and clinical practice realities of Māori nurses in Aotearoa New Zealand: The emotional labour of Indigenous nurses. *Nursing Praxis in Aotearoa New Zealand*, 36(3), 7-23. <https://doi.org/10.36951/27034542.2020.011>

Ngā ariā matua

He iti noa ngā rangahau tūhura uauatanga mō ngā tapuhi taketake Māori ina paihere i ngā whāinga ahurea ki roto i ngā mahi taurima tūrora, i Aotearoa. Tā tēnei rangahau he tūhura he pēhea te hīkoi a ngā tapuhi Māori ina hora i te manaakitanga tika ā-ahurea ki ngā iwi, ki ngā hapū me ngā whānau Māori huri noa i ngā horopaki manaakitanga hauora huhua. I kawea tētahi rangahau paki taketake kounga hei hauhake raraunga. I whakahaeretia ētahi uiuinga āhua ōkawa nei ki ētahi tapuhi rēhita Māori, mātanga tapuhi hoki, 12 huia katoatia. I whāia ngā tikanga waihanga, whakaū i roto i te tātari tāhuhu. Kei ēnei paki he māramatanga mō ngā whakaaro ao taketake o ngā tapuhi, i puta ake i te tāpaetanga horopaki mō ō rātou wheako mahinga ngaio. E whā ngā tāhuhu matua i kārawarawatia mai i ngā raraunga: te tuakiri Māori; kawenga taumaha; te kaikiritanga; me tauutuutu. I pēhia auautia ngā mātanga Māori kia haere whaka-te-taha i roto i ngā ratonga manaakitanga hauora anga ki te tinana me ngā mahi tākuta anake. I kitea e ngā kaimahi ētahi tikanga mahi makihuhunu e puta ai pea he hē mō ngā putanga hauora. Ka pā haere tonu te taupatutapu ā-ahurea ki te puritanga i ngā tapuhi Māori ki tēnei ao mahi. He mea pai ki ngā kaimahi Māori ō rātou hoamahi o tauwi e mahi nei hei hoa, e whakaū nei i te taurimatanga i āta tāreia mō ngāi Māori.



Keywords / Ngā kupu matua

cultural safety / kawa whakaruruhau; emotional labour / mahi kare ā-roto; Indigenous / iwi taketake; Māori; racism / te kaikiritanga; registered nurse / tapuhi rēhita

Introduction

It is imperative that Māori practitioners and tauwiwi (non-Māori), as cultural allies, acknowledge the dual cultural and clinical acumen of Māori nurses to reduce significantly Indigenous health inequities (see Appendix for glossary of Māori terms). For many Māori, healing comes from being immersed in culturally congruent environments where mātauranga Māori (traditional knowledge) and te ao Māori (the Māori world) are embraced. Healing involves drawing from models of health grounded in Indigenous priorities. These models involve an integrated healthcare approach that acknowledges whakapapa (genealogy), wairua (spirituality), whanaungatanga (sense of family connection), and connections to society and the environment (Durie, 1994; Pitama et al., 2007; Wilson & Hickey, 2015). A visible Māori health workforce with inherent understanding of diverse socio-cultural contexts demonstrates to the wider workforce how culturally safe, competent, and clinically effective care manifests relationally.

Māori nurses within the Aotearoa health workforce typically join organisations designed within a Western biomedical model of governance and delivery. Likewise, Māori patients and whānau (extended family) predominantly access tauwiwi provider services across the health and disability system (Health & Disability System Review, 2020). Here the interminable effects of colonisation, including assimilation and breaches to the 1840 treaty between Māori and British settlers, continue to erode Indigenous cultural systems. Inequities in health persist as an outcome of differential exposure to health determinants (Curtis et al. 2019; Moewaka Barnes & McCreanor, 2019; Waitangi Tribunal, 2019). Extant research shows that Indigenous Māori, including nurses,

experience marginalisation, discrimination, and all levels of racism (Came, 2014; Came et al., 2019; Harris et al., 2006; Houkamau et al., 2017; Huria et al., 2014; Reid et al., 2019). Inequities manifest despite the promises and obligations exchanged in te Tiriti o Waitangi (the Treaty of Waitangi), the founding document of Aotearoa New Zealand signed in 1840. This treaty, recognised legally as a core constitutional document, acknowledges the bicultural commitment between Māori and British Crown as two partners. The agreement affirmed tino rangatiratanga (political authority) and assured the protection of hauora Māori (health).

Social and economic determinants of health inequity include access to services and delivery of appropriate care. Equity in Aotearoa as defined by the Ministry of Health (2019) involves “recognising that different people with different levels of advantage require different approaches and resources to get equitable health outcomes.” Throughout the life course, Māori experience inequitable access to health services leading to higher rates of disability and multiple morbidity (Health Quality & Safety Commission, 2019; Palmer et al., 2019). In comparison to tauwiwi, Māori patients experience lower quality care across the spectrum of services (Davis et al., 2006); are less likely to be prescribed more effective medications (Metcalf et al., 2013); and are referred less often to have investigations, interventions, or receive specialist services (Ministry of Health, 2015; Robson et al., 2006). The Waitangi Tribunal claim WAI 2575 opened in 2016 to hear grievances about the health system and identified profound colonial system failure to deliver equitable Māori health outcomes (Came, et al., 2020). To reduce health inequities, strengthened Māori participation is imperative in the shaping of care delivery.



Development of a more representative Māori nursing workforce is essential to advance health policy, workforce strategies, and improve wellbeing for Māori (Chalmers, 2020; Health & Disability System Review, 2020; Ministry of Health, 2014; Wilson, 2018). Aspirations to increase Māori nurse representation since the 1980s have had limited effect (Wilson & Haretuku, 2015). There remains a marked underrepresentation in a population comprising 16.5% Māori (Statistics New Zealand, 2018). Recent statistics show Māori nurses represent 8% (4,206) of the total nursing workforce; including 9% of all nurse practitioners (NPs), 8% of registered nurses (RNs) and 10% of enrolled nurses (Nursing Council of New Zealand (NCNZ), 2019). Forty percent of all RNs, including 35% of all Māori RNs, most commonly worked in the acute District Health Board (DHB) employment setting; with the next largest workforce, including 18% of all Māori RNs, employed in primary health and community care. Of this 18%, the community-based health provider setting with the highest percentage was Maori health service provider (62%); followed by rural (14%); Pacific health service provider (12%); and community DHBs (11%) (NCNZ, 2019). The unequal treatment of Māori nurses and clients is well-recognised within these primary healthcare settings (Waitangi Tribunal, 2019).

As the largest health workforce, all nurses are potentially well positioned to champion the decolonisation of systemic processes that sustain Indigenous disparities, yet they work in a system that is highly racist. Over fifty-six thousand practising nurses are registered by the regulatory authority, the Nursing Council of New Zealand (Health & Disability System Review, 2020; NCNZ, 2019). For these nurses the basis for analysis of Māori healthcare realities is knowledge of *te Tiriti* and *kawa whakaruruhau* - cultural safety - within its original context of nursing Māori. Culturally safe practice involves a commitment from practitioners to decolonise thinking and counter practices which diminish, demean, or disempower the unique identity and wellbeing of Māori (Ramsden, 1990). Alongside advancing generic

relational skills, nurses' reflexive practice on their own power, privileges and biases in relation to their role, the role of the health system, and broader socio-economic factors is deemed essential for achieving regardful care (Curtis et al., 2019; McEldowney and Connor, 2011). Cultural safety is one approach towards disqualifying the coloniality and institutional racism that exists.

For three decades cultural safety has been embedded into nursing's competency assessment framework (NCNZ, 2007, 2011). Ethical principles from *te ao Māori* are further interwoven throughout the aspirations of the national Code of Ethics (New Zealand Nurses Organisation, 2019); principles also draw from the United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2008). The national Code of Conduct further centralises culturally safe practice competencies for all nurses (NCNZ, 2012). Within these documents, the fundamental expectation is that a culturally safe nursing workforce will promote social justice, cognisant of socio-political and historical inequities. Despite decades of espoused commitment to cultural safety in nursing codes, education, and practice, racial biases persist (Graham & Masters-Awatere, 2020).

It is important to note substantial changes in healthcare provision over the years with staffing shortages has resulted in an over-reliance on internationally qualified nurses, now representing 27% of the overall workforce (Chalmers, 2020; NCNZ, 2019); leading to further marginalisation of Māori, who are often seen as one culture amongst many. Alongside biomedically-driven social and health approaches that focus solely on diagnostic models, neoliberal health reforms have focused on individual responsibility for healthcare, entirely at odds with Māori models of health. To rectify the ongoing systemic Indigenous cultural failings all health services must have policies that require the capability to engage with Māori in ways that endorse cultural identity, values, and approaches (Came, et al., 2020; Health & Disability System Review, 2020). Rather



than promotion of western ethnocentrism and moral universality that do little to achieve culturally congruent care, the authors concur that consideration of diverse ethical and sociocultural realities and moral viewpoints is needed (Hunter & Cook, 2020). There is a paucity of research exploring tensions for Māori nurses when integrating cultural priorities into their clinical practice. This study explored how Māori nurses experienced the delivery of care to iwi, hapū, and Māori whānau across different health care employment settings in Aotearoa.

Method

A qualitative Māori-centred narrative inquiry was used to obtain data (Ware et al., 2017). Qualitative research uses a systematic, subjective approach to describe activities in the social realm, and when aligned with Indigenous epistemologies, informs understanding of Indigenous realities (Grove & Gray, 2018; Tuhiwai Smith, 2005). Māori engage in *kōrero*, the sharing of stories, creating a knowledge repository. Narrative inquiry enables reflexivity and co-construction of narratives. A Māori-centred approach affirms Indigenous *tino rangatiratanga* and represents experiences of marginalisation in an authentic way (Tuhiwai Smith, 2004). Aligned with Māori research guidelines (Francis et al., 2019; The Pūtaiora Writing Group, 2010), there was significant partnership with Māori through all steps of the research process, from study conceptualisation through to dissemination. The first author identifies as Māori.

Participants

This study used purposive sampling to recruit participants typical of the population (LoBiondo-Wood & Haber, 2014). The eligibility criteria were that participants had to self-identify as Māori, be a New Zealand registered nurse, and be employed in a clinical practice setting in Aotearoa. Sixteen clinically-based nurses initially responded to an advertisement and 12 proceeded to interview during 2019. All participants identified

as female, aged between 25-53 years. Participants gained initial entry-to-practice nursing qualifications between 1986-2018. Three had entered practice within the previous two years, and the remaining nine held postgraduate (PG) nursing qualifications: four with a PG certificate; one with a PG diploma; and four with a Master's degree, including two NPs. All 12 worked for different healthcare organisations. Seven worked in mainstream DHB employment settings; acute, or community mental health, or primary health. Five, including both NPs, were employed by dedicated Māori health services providers; in either community mental health, or primary health community care.

Wilson (2006) highlights that contemporary Māori are diverse as a result of differing tribal affiliations, colonising experiences, urbanisation, interethnic marriages, and education. Likewise, study participants presented with a broad range of experiences that shaped their identity. Some had traditional Māori upbringings on *tūpuna* whenua (ancestral land) or attended *kura kaupapa* (Māori language immersion schools). Others lived away from *tūpuna* whenua, and acknowledged their bi-cultural heritage, with a strong and influential *tauwiwi* lineage. Fluency in *te reo* (Māori language) varied from fully fluent to limited fluency. A commonality for all participants, also reflected in the literature, is that *whānau* remains the fabric of Māori society, contributing to a strong sense of identity and collective responsibility (Wilson & Hickey, 2015).

Data collection

In alignment with an Indigenous narrative approach, data collection was carried out through semi-structured interviews (Greenhalgh et al., 2005). The first author and each of the 12 study participants engaged in a single interview lasting between 45-60 minutes. Two interviews were face-to-face and 10 via telephone due to geographical distance.



Data analysis and rigour

Narratives were reviewed, coded, and thematically analysed (Braun & Clarke, 2006). Frequently reported and significant themes, perspectives, and differences were identified inductively and deductively. As part of a rigorous approach all transcripts were read and coded by the second author and themes discussed. This reflexive and interactive approach facilitated the development of new insights.

Narrative Inquiry, when used as an Indigenous approach, is immersed in te Ao Māori, with a decolonising perspective. This orientation is cognisant of the impact and ongoing effects of colonisation, including the related power relations. Therefore, the researcher was mindful that participants' world views were shaped by the context of their lived experience (Kovach, 2010). Part of a decolonising approach means the researcher was alert to stories of racism that were not necessarily apparent to the participants in their accounts.

Ethical considerations

Ethical approval for the study was granted by the Research and Ethics Committee of the lead author's tertiary institution (Application 36). Potential participants were informed of the purpose of the research via an emailed information sheet. Queries were addressed and written informed consent obtained. Interviews were digitally recorded with consent and transcribed under a confidentiality agreement. Participants were invited to review and comment on their own transcript and were provided with a summary of findings. Participants were assured of anonymity and confidentiality.

Findings

The data analysis identified four themes. Theme 1: *Te tuakiri Māori - cultural identity* explores participants' awareness of their situated-ness within their professional identity, which profoundly shaped their nursing practice. Theme 2: *Kawenga taumaha - bearing the burden* highlights the emotional labour for participants in

providing culturally responsive care in the face of ignorance. Theme 3: *Te kaikiritanga - racism* illustrates the ongoing obstacles to achieving health equity and professional advancement. Theme 4: *Tauutuutu - reciprocity* examines participants' experiences of support from tauwi and the development of deeper cultural understanding.

Theme 1: Te tuakiri Māori - cultural identity

This theme illustrates the ways participants worked to position themselves as Māori nurses, and how they were positioned by colleagues, patients, and whānau. All participants were aware that they were a minority within mainstream nursing education and practice. They were highly cognisant of the place of professionalism, yet they experienced tension between tauwi concepts of appropriate professional boundaries and the beliefs, values, and relationships that drive Māori cultural identity.

Participant 5 described how tauwi colleagues did not understand her cultural pride, having to repeatedly affirm her identity:

A lot of my colleagues didn't understand that I've always been Māori first, and the nursing career was just a pathway that I chose. For me, having that conversation all the time with other colleagues, saying "I don't choose to be Māori, I was born Māori." [Participant 5]

Participants spoke of the struggle to be recognised as a qualified nurse, with patients and members of the community demonstrating casual racism and prejudice through being unable to recognise a Māori person as someone with qualifications:

I'd say, "Yes, I'm Māori", and they'd say, "Are you trained, are you a nurse?" I'd say, "Yes, I'm a nurse". [They would respond] "But are you an actual nurse?" [Participant 1]

I do get the shock factor when people ask where I work. I usually say, "I work at the hospital", because I don't like to usually say where I work,



it's a very small community. And then they want to know where. And then they just have this, "Oh, oh!" [shocked voice]. It annoys me, because why can't I be a nurse there? Why can't I do what I do? I've had a good education, and I know who I am, and I know where I'm from, and I take all that with me to the bedside when I look after people. [Participant 4]

The above examples illustrate the social stigmatisation, being challenged about their claim to be a nurse because they did not meet the ongoing racial stereotypes about who is a nurse and who is an unqualified worker.

Given these challenges to professional cultural identity, Participant 6 affirmed the value of strength in Māori staffing numbers to advocate for and advance relevant care for minority groups:

... it's so evident when there's a strong Māori contingency of staff because it's not just one person asking questions at hand over about Māori patients, or Pacifica patients, or vulnerable patients, it's all of us. [Participant 6]

Participants faced dilemmas of offending Māori when cultural practices clashed with expected westernised ethical prescriptions about professional boundaries. They were conscious of being perceived as either disrespectful or unprofessional. Participant 12 described consciously omitting respectful cultural practices to fit in with mainstream nursing ideology:

I guess there's always that challenge of accepting gifts. As Māori we really like to thank people with a gift, or cake, or a cup of tea or something. And I think you kind of do it at your own discretion, but within our practice [Māori Health Provider], gifts are OK, they're acceptable, because if you don't accept it then it's obviously classed as disrespectful, but in that sense, at my other job [in mainstream] I probably wouldn't accept a gift... a bit of an ethical dilemma. [Participant 12]

Another participant described eventually feeling confident enough to meld cultural imperatives into her practice:

The realisation that actually, this [hugging a patient in greeting] feels right for me, so this is what I'm going to do, and that wasn't crossing any boundaries, but it was just what felt right as a Māori nurse when I was caring for patients. So I always felt, once I got over that, "Where do I fit as a nurse, and where do I fit as a Māori nurse?" Once that was established, I felt quite confident in being able to work in the manner that I work. [Participant 3]

The above two quotes illustrate the identity challenges for these participants; their perspective that nursing continues to represent and value for the most part a tauiwi world view. To fully align with such, a nursing identity meant to compromise cultural values. Māori nurses who remained in nursing forged a unique dual professional identity, strengthened by mātauranga Māori and te ao Māori. Participants highlighted the breadth of who was encompassed in their care. Participant 6 emphasised that caring for her went well beyond an individualistic person-centred approach, that individual wellbeing was strongly associated with the wellbeing of whānau:

... for me, it's just about, not just looking at the patient themselves, but their whānau and engaging them, and supporting them, and I know that we [in nursing] always talk about patient care, focused care, but actually it's about everybody that's in that room. [Participant 6]

Awareness of her cultural identity shaped participant one's approach to nursing and what for her constituted professional practice. She described the establishment of respectful and trusting relationships made effective through relatability and sharing of whakapapa (family lineage). She also drew attention to the importance of creating a sense of a place for patients to belong for their time in hospital:



I'm more myself in front of Māori patients. I share more of myself, where I'm from, my parents, my kids. I'm just, not less professional, but I'm more relaxed with them. I'm less the professional refined nurse, I'm just more of me, because I'm Māori that just happens to be a nurse. I always respect everyone. I knock on the doors. I know when we're [Māori whānau] in hospital, some of us are in there long term. That's their whare [place of residence]. That little room becomes their whare, so I respect that area as theirs as well. [Participant 1]

Participant 1 also shared a depth of understanding around diverse social and cultural realities, for example cultural concepts such as whakamā - an individual's experience of shame or embarrassment:

I asked lots of questions, "What do you want to do today? When do you want to get up? Do you want a shower? Do you want me to help you with your shower?" Just bits and pieces like that, so I let them lead me, and I watched them as to what they were doing. I noticed one of my patients would put her teeth under her pillow, and I said to her, "Do you want me to put them in a container?", and she said, "No, no, I'm too whakamā, I'll let it sit under the pillow", so I let them sit under her pillow. I had another man who put his teeth in his pocket, I didn't question it. I thought, he just wants to keep them there, he knows where they are, in his pocket. I guess things that I know that I've just learnt over my lifetime. I'm not going to jump in and do anything, because we're all different, I guess. [Participant 1]

There was emphasis throughout interviews of the importance of kotahitanga - enabling a collective approach to achieve and improve healthcare outcomes. The nurses did not want to compromise on time to talk with, be guided by, and develop a true relational rapport

or whakawhanaungatanga with patients and whānau before interventions were made.

Theme 2: Kawenga taumaha - bearing the emotional burden

All participants described what in effect was the additional emotional labour of kawenga taumaha - the heavy burden and deep sense of obligation to watch-over and advocate for the appropriate care of all Māori whom they encountered accessing their organisations. Participants' engagement in kaitiakitanga - the guardianship or preservation of care - was often met with disregard or lack of understanding from colleagues.

Participants described the moral orientation of their work, towards improving Māori health status and outcomes:

I love working at home and still do. I chose my career, working on my tūpuna whenua [ancestral land], so it's our obligation to look after our people, and to have the āhuatanga [attributes] to mahi [work] with our people right. Trying to ensure that our people are heard because the majority of them are going through some hard times. So, there is an obligation straight away to ensure that our people are okay. It's not with resentment, I feel blessed that I am Māori. [Participant 5]

Participant 7 described being sought out by Māori patients and whānau because of an inherent ability to make connections and endorse cultural identity and values in care delivery:

I became a bit of a Māori magnet ... so any Māori whānau that came into the ward, they would want me to look after them.... I got every social issue, and every Māori family [and] Māori patient that came through the door, because of the way I worked with them.... I'd do the whakawhanaungatanga and get to know where people were from at the start. That was as



important to me as screening them for an allergy.

To say, "Where are you from?" [Participant 7]

There were many stories of participants' practice wisdom that illustrate what is in effect the added sense of responsibility around ensuring manaakitanga (showing respect). The following emotive narrative illustrates the sensitivity and respect afforded to a kaumātua (male elder) who required assistance with cares:

I knew he was quite high up within the world of Māoridom ... and he had had a stroke, and he couldn't talk, and I just felt that the staff didn't treat him how he should have been treated, so I was allowed to shower him, so I was being very respectful of that, and afterwards when he was dressed, he needed to be fed as well, he couldn't feed himself. You know, the nurses would just go round and chuck bibs on all the patients that spilled food, so I would take the bib off him and tuck it in like a serviette, and I knew that he really appreciated that, even though he couldn't speak, he had tears coming out of his eyes. [Participant 3]

Participant 7 recounted feeling alienated when colleagues in mainstream critical care treated her endeavours to provide holistic care as a sign of disorganisation:

And the other nurses say to me, "Come on its 10 o'clock, they should have had their shower," and I'm like, "Yeah, but visiting hours aren't until 10.30 and they want their wife to help them have their first shower," and they're like, "We don't have time for that".... I become the foreigner in my workspace. [Participant 7]

Participants noted tensions around end of life care, particularly with regards to spiritual wellbeing practices or wairuatanga. Participant 1 spoke of diligence ensuring patients' rooms were blessed after a death:

Recently a patient passed away and I thought to myself, I need to make sure that room's blessed.... That room wasn't in my allocated list, but I feel really strongly about it, because

I've seen a patient pass away, and within an hour another patient's put in that room and the nurse refused to bless it, because it doesn't matter apparently. So, I watched things like that. [Participant 1]

There were many instances when participants' perceptions about the appropriate care of patients and whānau did not align with organisational schedules. Participants described 'workarounds' in these situations. One NP in a Māori Health service provided an example of juggling workload and kaitiakitanga, cognisant of treatment access inequity:

If I'm running late to something because I decided to sit longer with somebody, or work longer with a patient in distress, or I wasn't certain that if I left them that they would receive exactly what I wanted them to receive in their treatment plan.... I stick around and I don't particularly care if I run late to an informatics meeting ... my priority is making sure that I might only get one opportunity with that whānau. [Participant 11]

As a result of upholding their commitment to holistic care, these nurses carried an unmeasured and invisible emotional load, which included routinely witnessing whānau who did not receive the care they should, and not being supported by colleagues to provide care that was the right cultural fit.

Theme three: Te kaikiritanga - racism

Te kaikiritanga incorporates instances of cultural disregard, marginalisation, and actions which reinforce inequality, including the maldistribution of resources. Participants were conscious of Māori health inequities driven in part by personally mediated and institutionalised racism.

Participant 9 spoke of the tension for her in sometimes experiencing the limitations in her role as an advocate:

You still watch to see if the Māori patients get all of the resources coming to them that they will need. And sometimes you can see that the



doctors are not doing everything, you know? It's a hard one ... because our people have got so many other co-morbidities.... I can sort of feel that they give up on our people, quicker. Because our people come in sicker and harder [to treat]. [Participant 9]

Participant 6 reflected on feeling empowered to actively engage nurses' critical reflection around broader equity issues, including maldistribution of resources and interventions:

I know a lot of nurses don't like other people butting in on their patients, but sometimes I will go to that nurse and I'll say, "Hey look, I've just heard that your patient, I know he's Māori, is in a very similar situation to this patient, but not having the same medications ... do you think that that's fair, or do you think that's what they need?" I've only done that once or twice, and the nurse was sort of looking at me like ... "Back up the bus!" (laughs), but I kept saying to her, "I'm just wondering, because that really is unfair." And one of them did actually agree with me, and said, "Well actually yeah, I might just get that looked at." [Participant 6]

The vigilance and advocacy role was further emphasised by Participant 11 who noted colleagues appeared unaware that racial biases underpinned decisions such as waiting lists:

I'm finding that I often have to challenge the minds, the thinking of colleagues, and say, "How are you determining someone's worth when you're distributing a resource? ... like distributing appointments.... The ones with the highest complex needs are Māori, but you've selected less of them, and more of this other group that doesn't need the service as desperately." You know, I ask them, "How are they doing that?" And I say, "So you're just doing it on a system of your own values, and what you consider someone's worthiness," which then, they look at

me ... I actually said this in a meeting yesterday, "Well that's actually racism, you're selecting based on your racist attitudes." [Participant 11]

Participant 7 described task-oriented 'tunnel-vision' approaches to care that impacted on the provision of holistic care. Participants described colleagues engaged in routinised everyday practices that diminished, demeaned, and disempowered the unique identity and wellbeing of Māori and yet were not recognised as culturally unsafe:

We talk about the three P's [in reference to te Tiriti/the Treaty principles] and working in partnerships and protection, but we're saying, "Oh no, we send you out of the room while we do handover, and we've given them a wash because it's nine o'clock and the drains need to come out ..." you know ... these people have probably never had anybody see them without their clothes on their entire life other than their wife or their whānau, and we're taking that away from them, and saying it's easier if we do it, it's quicker if we do it. [Participant 7]

There were instances when advice pertaining to culturally relevant care of patients was undermined by tauwiwi nurses confusing equality and equity when assessing need. In the following example a Māori nurse described teaching a new graduate nurse the difference between equality and equity:

... she [new graduate] said the older nurses told her off, because she was undoing all their hard work. Their hard work was teaching him [patient] that he wasn't going to get any more care than anyone else, that he was no sicker than anyone else ... that he was only going to get these short amounts of time because they had other patients to deal with.... So I said to her, "Stop. No. What they're doing is wrong, and it's very entrenched ... giving people equality keeps him down there ... you give him the equity that that man needs, and he's going to start investing in the healthcare that we're giving him, and he's



going to have a better health outcome. If we do what they're doing, and just give him little snippets, what's his health outcome going to be? He's not even at the basic level of all these other patients." [Participant 1]

Many participants spoke of having their nursing educational and clinical pathways predetermined and limited by their Māori identity. Aware of this occurrence for others, Participant 6 had developed an early career strategy to ensure professional development:

Nobody's going to career block me, and I'm going to pay for the courses myself if I'm really interested in doing them, and I'll just take the time off to do them. I'm not answerable to anybody and I'm not going to have them say, "No" to me. So, I've gone ahead and I've done different courses. In my own time, paid for myself, because I wasn't going to have anyone say, "No [Participant], you can't do that." But the thing that I found, speaking to a lot of Māori nurses, is they do feel career blocked, they do feel that jobs that they've applied for, they've had people say, "Oh you're not quite ready for that yet." [Participant 6]

Participant 4 described the occurrence of "pigeon-holing" as a contributing factor for the comparatively low number of Māori nurses in acute mainstream areas:

I can see the barriers to Māori nurses coming into acute nursing where I am. In my opinion there is a belief that Māori should be in the community caring for our people at ground level, which is so important, and I 100% agree with it, because prevention should be our number one priority. The reality is though, that nine out of 11 beds in ICU are full with Māori patients. So as much as we want to prevent our people from coming to hospital, we still have to care for them in the hospital, so having a Māori nurse looking

after a Māori patient, I cannot put into words.

[Participant 4]

The opinion that Indigenous nurses' services were best utilised in community or primary care settings belied experience; that Māori patients are everywhere and benefitted from the presence of Māori nurses. These examples of differential assumptions and actions represent discrimination and reinforcement of inequalities.

Theme four: Tauutuutu - reciprocity

This theme represents where participants experienced biculturalism in practice, or the respectful exchange with people from other cultures which contributed to an improved sense of cultural safety.

Participant 4 explained the joy she experienced when a tauwiwi colleague committed to classes learning to speak te reo Māori and appreciated the connection to a deeper understanding of her Māori patients:

And I just went, "Oh [nurse], that's amazing." I'm not saying that every non-Māori needs to speak te reo, not at all, but what I'm saying is that you've gotta try so many different avenues to be able to break those barriers, and if that's one of them, then she's hitting it." And she said to me, "You know, I want to learn te reo. If I learn the language, then I'm going to learn the tikanga [customary protocols]." And I said, "Yeah, you are, because one can't go without the other." [Participant 4]

Participants described supporting the socio-cultural practices of other minority or marginalised ethnic cultures through shared learning:

I think it is about reciprocity. I will ask them about things if we're nursing people from their culture. It's a two-way street. I need to learn, and I need to learn how to pronounce stuff. As



much as I can speak to family members. You know, I looked after an Indian lady who didn't have any English, but luckily our amazing Indian nurses that we have, could communicate on my behalf, and I picked up a couple of words that were really important to them that I could use throughout the duties. [Participant 4]

Participant 7 saw the benefit of educating others by actively drawing parallels between common traditional cultural values:

We've got lots of Indian nurses as well, but it's really interesting, because I say to the Indians when they say, "Oh, there's all those people in there, and all those kids," and dah, dah, dah. Indian families are quite ... it's quite similar to the Māori culture, they live with their elders, they look after their elders, and they come in packs, and they get together and they eat and eat and eat, same as Māori, there's not much difference. They have big long ceremonies for celebrations, marriage, death, you know, they have their processes and their tikanga. So, I try and say that as much as I can, to make people realise. And when I've spoken to one of the older Indian nurses at work, and the Fijian Indians, they quite like that, so they start looking after Māori a bit better. They tell me, "Oh I looked after this man, and he said 'Kia ora' to me," and I'm like, cool! [Participant 7]

Participant 2 gave an example of collegial responsiveness when she spoke up about the inappropriate dual use of a microwave. This seemingly everyday example highlights a practice that can be so ordinary for some ethnicities but is a major breach of protocol for Māori around separating anything related to food from equipment used for bodily care:

I was working at the hospital when I was a student nurse, and they had a set of best practice

guidelines, for Māori ... practices ... and so in one of them it said that a microwave will be provided for food, and then one would be provided for other things like heat packs, and they wouldn't get mixed up, because [of] tapu [that which is sacred] and noa [freed from tapu], and then I saw them using these wheat packs in the food microwave, and I went to the clinical leader, and I was like, "Oh, I don't think you're meant to be doing that," and I told her why, and within that day there was another microwave there, specifically for that. [Participant 2]

Participant 6 shared with pride the well-received palliative care she had provided for a tauwiwi patient and family:

... they'd said [family], "Mum's on her last days," and I said, "I'm really sorry about that," and talked to them about what's their plan, and how do you want to, what sort of care do you want for her right now, all those sort of things, and to me that's very Māori, just that whole connection, and trying to engage with them in the way that they want, because their mum could no longer tell me what she wanted. And when their mum actually passed ... they all said to me, "How amazing your care was [participant], you didn't just think about mum, you thought about all of us, and how we were feeling." ... I get quite teary about it, because if that's what you can do for Pākehā (non-Maori European), that's exactly what we do for Māori ... it personifies it because you're thinking about tikanga and karakia (prayer) ... and all those sort of things. [Participant 6]

The healthcare experience reaffirmed the value of reciprocity, and incorporation of Indigenous beliefs and values alongside everyday professional practice.



Discussion

Across the dataset were stark examples of participants' emotional labour; of personally mediated and structural racism; and the gap between culturally safe practice rhetoric and practice realities. The authors found no literature that connected the concept of emotional labour to the work of Indigenous nurses. However, we consider this concept has merit in assisting the visibility of what is often an intangible burden carried by Indigenous nurses. The concept of emotional labour was first coined by sociologist Arlie Hochschild (1983), to articulate the heightened requirements of workers in some jobs to display emotions deemed desirable, associated with that group, or to conceal emotions that are deemed not to reflect the values of that group. Emotional labour requires affective sensitivity and is integral to nursing work; for example, supporting the patient's decision to decline haemodialysis as palliative treatment; remaining outwardly calm in crises. However, our data highlighted many instances where participants in effect described modifying the outrage and distress they felt when they encountered institutionalised and personally mediated racism (Jones, 2000); and had to maintain a professional demeanour in the face of direct abuse.

Our study found that Māori nurses who worked in isolation in predominantly mainstream organisations frequently experienced discriminatory practices and racial biases that profoundly affected them. In this study, participants' facilitation of whānau involvement and cares incorporating spiritual dimensions, including karakia and the upholding of the tapu and noa, were overwhelmed by clinical priorities that colleagues deemed more important. Participants' efforts to integrate te reo Māori and tikanga practices into clinical areas were also not always sustainable. Walker (2015) reported Māori nurses working in similar environments had to justify their approaches to whānau-centred care, including the facilitation of spiritual needs. Similarly, Huria et al.'s (2014) study identified that while Māori nurses' clinical skills were valued their cultural skills or ability to implement

cultural imperatives were often not. A fundamental point made within a further qualitative study is the sense of obligation for Māori nurses to ensure that rituals associated with spiritual wellbeing occur, "because to do otherwise spiritually risked misfortune" (Wilson & Bakers, 2012 p. 1077). Any such constraint towards implementation of customary practices that protect and maintain the integrity of spiritual wellbeing, represent ongoing marked dislocation between Indigenous cultural values and Westernised systems and rules. Clinical peers' disregard for the embodiment of culturally safe practice, whether intentional or not, indicates institutional-level failure to recognise tino rangatiratanga, or the empowerment of individual practitioners.

Our study demonstrates there is still much to do to embed cultural safety as an ethic of care into the everyday practices of all nurses when working with Māori. Giddings argued that "[n]ursing remains attached to the ideological construction of the White good nurse" (2005, p. 304). Participants in the current study highlighted multiple disturbing examples of where this ideology persists, despite decades of cultural safety education in nursing. As illustrated in the quote pertaining to the new graduate nurse in the theme, *Te kaikiritanga - racism*, some nurses had entrenched attitudes around equality and believed that best practice was treating all patients the same. Nurses' culturally safe and culturally competent practice are not yet assured across all healthcare settings. The current formal process of competency assessment in Aotearoa gives nurses a superficial and incorrect view that they are providing culturally safe care, but they may be delivering care without critical analysis of the status quo (Hunter, 2020; Hunter & Cook, 2020). Measuring effectiveness and accountability for Māori health and wellbeing through the provision of health services reflects adherence to te Tiriti principles, in particular the principle of active protection (Waitangi Tribunal, 2019). An analysis of 16 professional bodies for regulated health practitioners including the NCNZ showed variation within cultural competency standards



around explicit requirements for action and integration of cultural responsiveness in the health sector (Heke et al., 2019). In nursing, leaders in education, employment, policy, and regulation must strengthen actions and accountabilities for culturally safe nursing care. Rigorous educational, guidance and role-modelling processes are required to support '*Pae ora*' - *healthy futures for Māori* (Ministry of Health, 2014, 2020).

The findings of this study highlight Indigenous nurses' aspiration and dedication towards reducing inequities in health for Māori. All participants described the additional workload, in order to nurse whānau, hapū, and iwi with integrity; making cultural needs integral to care rather than routinely prioritising clinical aspects. The availability of practice guidelines, policies, and Māori models of health does not necessarily relieve Indigenous nurses of feeling compelled to act as persuasive advocates and educators around what are everyday appropriate cultural responses. The nurses in this study had developed strategies to deal with experiences of racism and injustice including the following: being selective about which 'battles' to actively address; drawing from moral courage to articulate concerns; and seeking trust and support from key people including whānau networks to either work openly or subversively alongside mainstream nursing for social justice and social change.

Māori nurses want tauwi nurses to work as culturally responsive allies and commit to addressing racial discrimination that overtly and inadvertently reinforce health inequalities. Findings in this study showed that Māori participants working within mental health and dedicated Māori health services, as well as some mainstream clinical areas could confidently incorporate mātauranga Māori and tikanga into their professional practice. These nurses were enabled in part by greater representation of numbers, culturally competent leadership, and tauwi bicultural champions dedicated

to integrating the practices of kawa whakaruruhau and tino rangatiratanga into organisational culture. Participants reported that often nurses from other ethnic and tribal cultural backgrounds readily understood the experience of negotiating between traditional values and those of the dominant culture. Openness to developing knowledge of socio-cultural practices involving tikanga and language, alongside awareness of the socio-political context, contributes to a social element of culturally safe practice (Hunter & Cook, 2020; Woods, 2010). Beyond knowledge of cultural practices and social justice lies an ethic of care that involves compassion, trust, and respect. We await with interest to see whether the latest New Zealand Health and Disability System Review (2020) brings policy and practice changes that ensure Māori have control over hauora, including the quality, direction, and shape of healthcare practices and encounters.

Conclusion

This study contributes insights into Indigenous cultural practices in clinical practice settings across Aotearoa. Māori nurses' emotional labour was evident in their endeavour to deliver culturally safe care, weathering persistent structural and attitudinal barriers. Healthcare leaders need to be vigilant about critiquing practices that reinforce dominant culture perspectives and perpetuate discrimination. Kawa whakaruruhau, or culturally safe practice that has Māori at the epicentre, is an ongoing process of learning about self and the ability to perceive and respect diversity and differing world views. Healthcare is plagued with rhetoric that diversity matters, while there is ongoing systemic undergirding of a largely mono-cultural healthcare structure. Healthcare organisations must question the impact on health outcomes and workforce when nurses who identify as Māori cannot meet the needs of Māori within the parameters of their job descriptions. Decolonising nursing practice to achieve equity in healthcare for Indigenous Māori remains a work in progress.



Acknowledgements: The authors remain grateful to the 12 nurses who shared wholeheartedly about the complexities of their role. The authors would also like to acknowledge the support of the primary author's educational institute Kawa Whakaruruhau Nursing Advisory, and any additional te reo expertise and Indigenous knowledge provided. The reviewers' comments have been invaluable in refining the concepts within this article.

Statement: Kiri Hunter and Catherine Cook as co-authors and editorial board members of Nursing Praxis in Aotearoa New Zealand excluded themselves from all review, editorial, and publication decisions for the article, consistent with journal policy.

He moana pukepuke e ekengia e te waka

A choppy sea can be navigated by a waka

References

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in Psychology*, 3, 77-101. <https://doi.org/10.1191%2F1478088706qp063oa>
- Came, H. (2014). Sites of institutional racism in public health policy making in New Zealand. *Social Science and Medicine*, 106, 214-220. <http://dx.doi.org/10.1016/j.socscimed.2014.01.055>
- Came, H., McCreanor, T., Manson, L., & Nuku, K. (2019). Upholding Te Tiriti, ending institutional racism and Crown inaction on health equity. *New Zealand Medical Journal*, 132(1492), 61-66.
- Came, H., O'Sullivan, D., Kidd, J., & McCreanor, T. (2020). The Waitangi Tribunal's WAI Report: Implications for decolonizing health systems. *Health and Human Rights Journal*, 22, 209-220. <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2469/2020/06/Came.pdf>
- Came, H., O'Sullivan, D., & McCreanor, T. (2020). Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy. *Ethnicities*, 20, 434-456. <https://doi.org/10.1177/1468796819896466>
- Chalmers, L. (2020). Responding to the State of the World's Nursing 2020 report in Aotearoa New Zealand: Aligning the nursing workforce to universal health coverage and health equity. *Nursing Praxis in Aotearoa New Zealand*, 36(2), 7-19. <https://doi.org/10.36951/27034542.2020.007>
- Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S-JK., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, 18(174), 1-17. <https://doi.org/10.1186/s12939-019-1082-3>
- Davis, P., Lay-Yee, R., Dyal, L., Briant, R., Sporle, A., Brunt, D., & Scott, A. (2006). Quality of hospital care for Māori patients in New Zealand: Retrospective cross-sectional assessment. *Lancet*, 367(9526), 1920-1925. [https://doi.org/10.1016/S0140-6736\(06\)68847-8](https://doi.org/10.1016/S0140-6736(06)68847-8)
- Durie, M. (1994). *Whaiora: Māori health development*. Oxford University Press.
- Francis, H., Carryer, J., & Cram, F. (2019). Consulting with Māori experts to ensure mainstream health research is inclusive of Māori. *Nursing Praxis in New Zealand*, 35(3), 7-14. <https://doi.org/10.36951/NgPxNZ.2019.010>
- Giddings, L. (2005). Health disparities, social injustice, and the culture of nursing. *Nursing Research*, 54, 304-312. <https://doi.org/10.1097/00006199-200509000-00004>
- Graham, R., & Masters-Awatere, B. (2020). Experiences of Māori of Aotearoa New Zealand's public health system: A systematic review of two decades of published qualitative research. *Australian and New Zealand Journal of Public Health*, 44, 193-200. <https://doi.org/10.1111/1753-6405.12971>
- Greenhalgh, T., Russell, J., & Swinglehurst, D. (2005). Narrative methods in quality improvement research. *Quality and Safety in Healthcare*, 14, 443-449. <https://doi.org/10.1136/qshc.2005.014712>
- Grove, S., & Gray, J. (2018). *Understanding nursing research: Building an evidence-based practice* (7th ed.). Saunders Elsevier.
- Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: Cross-sectional study. *The Lancet*, 367(9527), 2005-2009. [https://doi.org/10.1016/S0140-6736\(06\)68890-9](https://doi.org/10.1016/S0140-6736(06)68890-9)



- Health Quality & Safety Commission. (2019). He matapihi ki te kounga o ngā manaakitanga ā-haoura o Aotearoa 2019. *A window on the quality of Aotearoa New Zealand's health care 2019*. Author. https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Window_2019_web_final.pdf
- Heke, D., Wilson, D., & Came, H. (2019). Shades of competence? A critical analysis of the cultural competencies of the regulated-health workforce in Aotearoa New Zealand. *International Journal for Quality in Health Care*, 31(8), 606-612. <https://doi.org/10.1093/intqhc/mzy227>
- Hochschild, A. (1983). *The managed heart: Commercialization of human feeling*. University of CA Press.
- Houkamau, C., Stronge, S., & Sibley, C. (2017). The prevalence and impact of racism towards Indigenous Māori in New Zealand. *International Perspectives in Psychology: Research, Practice, Consultation*, 6, 61-80. <https://doi.org/10.1037/ipp0000070>
- Health and Disability System Review. (2020). *Health and Disability System review: Final report - Pūrongo Whakamutunga*. Author. <https://www.systemreview.health.govt.nz/final-report>
- Hunter, K. (2020). Cultural safety or cultural appropriation? *Kai Tiaki: Nursing New Zealand*, 26(1), 24-25.
- Hunter, K. & Cook, C. (2020) Indigenous nurses' practice realities of cultural safety and socioethical nursing. *Nursing Ethics*, 27, 1472-1483. <https://doi.org/10.1177/0969733020940376>
- Huria, T., Cuddy, J., Lacey, C., & Pitama, S. (2014). Working with racism: A qualitative study of the perspectives of Māori (Indigenous peoples of Aotearoa New Zealand) Registered Nurses on a global phenomenon. *Journal of Transcultural Nursing*, 25, 364-372. <https://doi.org/10.1177/1043659614523991>
- LoBiondo-Wood, G., & Haber, J. (2014). *Nursing research: Methods and critical appraisal for evidence-based practice* (8th ed.). Elsevier Mosby.
- Jones, C. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*, 90, 1212-1215. <https://doi.org/10.2105/ajph.90.8.1212>
- Kovach, M. (2010). Conversational analysis in Indigenous research. *First Peoples Child & Family Review*, 5, 40-48. <https://fpcfr.com/index.php/FPCFR/article/view/172>
- McEldowney, R., & Connor, M. J. (2011). Cultural safety as an ethic of care: A praxiological process. *Journal of Transcultural Nursing*, 22, 342. <https://doi.org/10.1177/1043659611414139>
- Metcalfe, S., Laking, G., & Arnold, J. (2013). Variation in the use of medicines by ethnicity during 2006/07 in New Zealand: A preliminary analysis. *New Zealand Medical Journal*, 126(1384), 14-41.
- Ministry of Health. (2014). *A guide to He Korowai Oranga: Māori Health Strategy*. Author. <https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga>
- Ministry of Health. (2015). *Tatau kahukura: Māori health chart book 2015* (3rd ed.). Author. <https://www.health.govt.nz/publication/tatau-kahukura-maori-health-chart-book-2015-3rd-edition>
- Ministry of Health. (2019). *Achieving equity*. Author. <https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity>
- Ministry of Health. (2020). *Whakamaua: Māori Health Action Plan 2020–2025*. <https://www.health.govt.nz/publication/whakamaua-maori-health-action-plan-2020-2025>
- Moewaka Barnes, H., & McCreanor, T. (2019). Colonisation, hauora and whenua in Aotearoa. *Journal of the Royal Society of New Zealand*, 49, 19-33. <https://doi.org/10.1080/03036758.2019.1668439>
- New Zealand Nurses Organisation. (2019). *NZNO Guideline: Code of Ethics*. Author. <https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Code%20of%20Ethics%202019.pdf?ver=19LQpYx8wsprijbTnt9pWw%3d%3d>
- Nursing Council of New Zealand. (2007). *Competencies for Registered Nurses*. Author. https://www.nursingcouncil.org.nz/Public/Nursing/Scopes_of_practice/Registered_Nurse/NCNZ/nursing-section/Registered_nurse.aspx?hkey=57ae602c-4d67-4234-a21e-2568d0350214
- Nursing Council of New Zealand. (2011). *Guidelines for cultural safety, the Treaty of Waitangi and Māori Health in nursing education in practice*. Author. https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx
- Nursing Council of New Zealand. (2012). *Code of Conduct for Nurses*. Author. https://www.nursingcouncil.org.nz/Public/Nursing/Code_of_Conduct/NCNZ/nursing-section/Code_of_Conduct.aspx?hkey=7fe9d496-9c08-4004-8397-d98bd774ef1b



- Nursing Council of New Zealand. (2019). *The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2018-2019*. https://www.nursingcouncil.org.nz/Public/News_Media/Publications/Workforce_Statistics/NCNZ_publications-section/Workforce_statistics.aspx?hkey=3f3f39c4-c909-4d1d-b87f-e6270b531145
- Palmer, S., Gray, H., Huria, T., Lacey, C., Beckert, L., & Pitama, S. (2019). Reported Māori consumer experiences of health systems and programs in qualitative research: A systematic review with meta-synthesis. *International Journal for Equity in Health*, 18(163), 1-12. <https://doi.org/10.1186/s12939-019-1057-4>
- Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). Meihana Model: A clinical assessment framework. *New Zealand Journal of Psychology*, 36(3), 118-35.
- Ramsden, I. (1990). *Kawa Whakaruruhau: Cultural safety in nursing education*. Ministry of Education, New Zealand. [https://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/707224BC1D4953C14C2565D700190AD9/\\$file/kawa-whakaruruhau.pdf](https://www.moh.govt.nz/NoteBook/nbbooks.nsf/0/707224BC1D4953C14C2565D700190AD9/$file/kawa-whakaruruhau.pdf)
- Reid, P., Cormack, D., & Paine, S.J. (2019). Colonial histories, racism and health: The experience of Māori and Indigenous peoples. *Public Health*, 172, 119-124.
- Robson, B., Purdie, G., & Cormack, D. (2006). *Unequal impact: Māori and non-Māori cancer statistics 1996–2001*. Ministry of Health. <https://www.health.govt.nz/publication/unequal-impact-maori-and-non-maori-cancer-statistics-1996-2001>
- Statistics New Zealand. (2018). 2018 Census quick stats about ethnicity. Author. <https://www.stats.govt.nz/tools/2018-census-place-summaries/new-zealand>
- The Pūtaiora Writing Group. (2010). *Te Ara Tika* guidelines for Māori research ethics: A framework for researchers and ethics committee members. <https://www.hrc.govt.nz/resources/te-ara-tika-guidelines-maori-research-ethics-0>
- Tuhiwai Smith, L. (2004). Researching in the margins: Issues for Māori researchers a discussion paper. *AlterNative: An International Journal of Indigenous Peoples*, 2, 4-27. <https://doi.org/10.1177%2F117718010600200101>
- Tuhiwai Smith, L. (2005). On tricky ground: Researching the native in the age of uncertainty. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (p. 85–107). SAGE Publications Ltd.
- United Nations. (2008). *United Nations declaration on the rights of Indigenous peoples*. Author. https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf
- Waitangi Tribunal. (2019). *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. WAI 2575. <https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/>
- Walker, L. (2015). Walking in two worlds. *Kai Tiaki: Nursing New Zealand*, 21(5), 34.
- Ware, F., Breheny, M., & Forster, M. (2017). Kaupapa Kōrero: A Māori cultural approach to narrative inquiry. *AlterNative*, 14, 45-53. <https://doi.org/10.1177%2F1177180117744810>
- Wilson, D. (2006). The practice and politics of Indigenous health nursing. *Contemporary Nurse*, 22(2), x-xiii. <https://doi.org/10.5172/conu.2006.22.2.x>
- Wilson, D., (2018). Why do we need more Māori nurses? [Editorial]. *Kai Tiaki: Nursing New Zealand*, 24(4), 2.
- Wilson, D., & Baker, M. (2012). Bridging two worlds: Māori mental health nursing. *Qualitative Health Research*, 22, 1073-1082. <https://doi.org/10.1177%2F1049732312450213>
- Wilson, D., & Haretuku, R. (2015). Te Tiriti o Waitangi/ Treaty of Waitangi 1840: Its influence on health practice. In D. Wepa (Ed.), *Cultural safety in Aotearoa New Zealand* (2nd ed., pp. 79-98). Cambridge University Press.
- Wilson, D., & Hickey, H. (2015). Māori health: Māori and whanau-centred practice. In D Wepa (Ed.), *Cultural safety in Aotearoa New Zealand* (2nd ed., pp. 235-251). Cambridge University Press.
- Woods, M. (2010). Cultural safety and the socioethical nurse. *Nursing Ethics*, 17, 715-725. <https://doi.org/10.1177/0969733010379296>



Appendix: Glossary of Māori terms

āhuatanga	way, characteristic, attribute
hapū	kinship group, sub-tribe
hauora	holistic health and wellbeing
iwi	extended kinship group, tribe, descended from a common ancestor
karakia	incantations and prayers, to invoke guidance and protection
kaumātua	adult, elder, a person of status within the whānau
kaupapa	central purpose, initiative, issue
kaitiakitanga	guardianship, protection of care
kawa whakaruruhau	cultural safety within the context of nursing Māori
kōrero	speech, sharing of stories
kotahitanga	unity or sense of togetherness, collective action
kura kaupapa	Māori language immersion school
mahi	work, job, employment, practice
manaakitanga	show respect, kindness, hospitality, support
Māori	Indigenous peoples of Aotearoa New Zealand
Māoridom	the world or sphere of the Māori people
mātauranga	Māori knowledge, traditional knowledge
noa	to be safe and normal, unrestricted
Pākehā	non-Māori, European
taha wairua	spiritual component
tapu	sacred or prohibited, restricted
tauīwi	foreigner, non- Māori, colonist
te ao Māori	the Māori world view
te reo Māori	the Māori language
Te Tiriti o Waitangi	The Treaty of Waitangi
tikanga	Protocol, the customary system of values and practices
tino rangatiratanga	the fullest expression of rangatiratanga, autonomy, self-determination, sovereignty, self-government
tūpuna whenua	ancestral land
wairua	spirit
wairuatanga	spirituality
whakamā	to be ashamed, shy, bashful, embarrassed
whakapapa	genealogy, lineage, descent
whakawhanaungatanga	process of establishing relationships
whānau	extended family, family group
whanaungatanga	relationship, sense of family connection
whare	house, residence
whenua	land

To access the Nursing Praxis te reo glossary, please go to our website <https://www.nursingpraxis.org/maori-research-te-reo.html>