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MĀORI NAVIGATING GUT SYMPTOMS

"I mean, who gets cramp that often in their puku?"

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Abstract

Gut diseases are a major cause of morbidity and mortality in Aotearoa New Zealand, with higher rates of these conditions in Te Waipounamu. Māori experience both worse outcomes and different patterns of incidence in gut diseases than non-Māori. Overall, Māori have lower life expectancies than non-Māori and experience barriers to accessing determinants of health. We aim to illuminate how Māori understand the gut and navigate the health system when the topic is the gut and gut disease, based on interviews with Māori participants in a wider study of gut symptoms. Participants explored a range of issues related to gut disease, including interactions people had with healthcare providers surrounding these conditions. They frequently felt "brushed off" or disengaged from healthcare, which could contribute to delayed diagnosis. Results indicate there may be value in promoting more widespread uptake of existing cultural competence models designed for healthcare practitioners. Findings have implications in New Zealand and other postcolonial environments.

Keywords

gut disease, primary healthcare, Māori

Introduction

Gut disease is a major cause of morbidity and mortality in Aotearoa New Zealand. Gut diseases include cancers (e.g., colorectal cancer), coeliac disease, Crohn's disease and ulcerative colitis, among others. New Zealand has, for some conditions, the highest rates in the world, with specific issues evident. First, there are high rates of colorectal cancer (Health Quality and Safety Commission, 2017), inflammatory bowel disease (Gearry et al., 2006; Su et al., 2016), coeliac disease (B. Cook et al., 2004; H. B. Cook et al., 2000)

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and functional gastrointestinal disorders (Barbezat et al., 2002). Māori are diagnosed at a later stage and have higher mortality than non-Māori for colorectal cancer (Gurney et al., 2020; Sharples et al., 2018). Māori have lower rates of inflammatory bowel disease (Coppell et al., 2018; Gearry et al., 2006) and lower rates of diverticular disease, but present at significantly younger ages (Broad et al., 2019; Varghese et al., 2021). Outcomes for gut cancers are poor in Aotearoa compared with other countries (Alafeishat et al., 2014), with increasing incidence and mortality in people aged less than 50 years (Chittleborough et al., 2020; Gandhi et al., 2017).

Diagnosis can be challenging (Esteva et al., 2013; Shahid et al., 2016; Vavricka et al., 2016). Treatments, including medical and surgical options, are often more effective when commenced earlier (Lee et al., 2017). However, before investigation and any treatment can begin, patients need to recognise and report their symptoms. People sometimes put off having symptoms of bowel or gut disease investigated, and this can cause delays in diagnosis and treatment (Brown et al., 2017; Hall et al., 2015; Lewis et al., 2018; Oberoi et al., 2015; Thompson et al., 2012). Not everyone has smooth access to healthcare and an easy route through the health system (Björkman et al., 2016; Casiday et al., 2009; Lee et al., 2017; Lesnovska et al., 2017; Vavricka et al., 2012, 2016). This situation is particularly acute for Māori.

It is well documented that Māori continue to experience a range of barriers to accessing and receiving appropriate and timely healthcare at all levels of the healthcare system (Espiner et al., 2021; Graham & Masters-Awatere, 2020; Rahiri et al., 2018; Slater et al., 2013). Māori health inequities are often framed as individual failure rather than a failure of structures and institutions set up to serve non-Māori, while systematically disadvantaging Māori (Reid et al., 2017; Smith, 2012). Research suggests, for example, that Māori have poorer access to the determinants of good health, and are subject to institutional racism within the health system, which affects both access to and quality of care for them (Gurney et al., 2019). New Zealand's primary healthcare policy and delivery for Māori was subject to an extensive inquiry by the Waitangi Tribunal (2019). Findings show that inadequate funding of Māori primary healthcare providers has disproportionately affected Māori, with many reporting unmet need for primary healthcare due to cost. The importance of taking time to establish a connection with Māori patients was also raised as an issue by Māori service providers, who noted that the mainstream funding model did not take this into consideration (Waitangi Tribunal, 2019).

In this paper we aim to illuminate how Māori understand the gut and navigate the health system when the topic is the gut and gut disease. Because of the often vague, intermittent and sometimes embarrassing nature of gut symptoms, timely diagnosis of gut diseases relies on thorough and sensitive clinical care. Therefore, the experiences Māori have when accessing the healthcare system for gut-related issues may be important in identifying factors that contribute to inequities. We also discuss the ways that the health system could be more responsive to Māori.

Methods

This paper is based on data from interviews with 16 Māori participants recruited into a larger study designed to qualitatively investigate understandings of gut disease and experiences of care seeking in relation to gut health. In the larger study, we interviewed 44 people around Te Waipounamu, including 28 people with gut disease (oesophageal and bowel cancer, Crohn's disease, diverticulitis, coeliac disease, irritable bowel syndrome, reflux, gastritis or gall bladder disease). Most had been diagnosed within the past two years. Five other people had a history of symptoms suggestive of gut disease and had undergone investigations but had never had a formal diagnosis. We also talked to 11 people without any symptoms or gut disease diagnosis. Some of the people with diagnoses were referred by hospital specialists and cancer nurses from district health boards in Te Waipounamu, and the remainder were identified through community contacts. The people without a diagnosis were all located through researcher community contacts. Ethical approval for the study was received from the University of Otago Human Ethics Committee (Health) [No. H21/039].

Both lead authors-interviewers identify as Māori and are experienced Kaupapa Māori researchers with a commitment to improving hauora Māori. For the sampling and interviews, we followed Māori processes of engagement (Smith, 2012) with participants, for example, beginning an interview with karakia and mihi if appropriate. Generally, AH, who is a Māori male, carried out interviews with Māori men, and CM carried out interviews with Māori women.

Participants were interviewed in their own homes or other location of their choosing. Interviewers spent time on whanaungatanga (building a shared connection with participants) before beginning questions about the topic. The interviews were semi-structured and followed an interview schedule designed to explore the experience of gut symptoms, diagnosis and disease with Māori. The interview guide enabled participants to talk in depth about their experiences. Participants were given a $20 voucher as koha, and kai. All interviews were recorded and then transcribed by a professional transcriber who had signed a confidentiality agreement. All participants were offered their transcriptions for checking before analysis, and two Māori participants took this opportunity. All transcripts were read and discussed by members of the team, and thematic analysis (Braun & Clarke, 2006) was carried out. The themes were generated inductively, and AH and CM led this Māori-specific analysis, with a focus on allowing the Māori participant voice to emerge in relation to our research question.

Results

This paper is based solely on the 16 interviews with Māori participants. Participants ranged in age from 20s to over 65. We interviewed two people who did not have any symptoms. The remaining 14 participants had cancers, coeliac disease, diverticulitis, reflux, gastritis, irritable bowel syndrome or other gut symptoms but no formal diagnosis. Several lived rurally. We do not provide any demographic information about this group in the quotations included in the paper, due to the potential for individuals to be identified. Quotations pertain mainly to experiences of the primary care system.

Inductive thematic analysis generated three major descriptive themes: talking about the gut and deciding to seek care, being brushed off and breaking the cycle and healthcare relationships in mainstream systems.

Talking about the gut and deciding to seek care

To come to a point of deciding to seek care, people first needed to describe to themselves, and sometimes others, what was going on with their gut. People had a range of ways of talking about the gut. Not everyone liked or related to the word *gut*, but it was a starting point for conversation. People used Pākehā words to talk about the gut, but puku was also widely used by Māori. For some this meant the whole gut, and for others just part of it. Some saw *puku* as a term that you grew out of using as you grew older. Some people used *nono* as well. Not everyone felt comfortable talking about the gut, either in their family or in healthcare settings. For some this was to do with seeing the body as sacred and other survival needs taking priority:

> The body is something that's sacred and not really discussed about . . . Growing up we never really talked about gut health, but having a healthy puku, I think, growing up, was more like, you're fed—if you're fed, then you're healthy . . . We weren't educated on what's good for our health, for our puku. We were educated on how to gather kai, how to cook it and how to be grateful for it.

Describing symptoms to a doctor could be awkward, especially at first. Many participants commented that bowel function was not "the easiest thing" to talk about. Overcoming the awkwardness was more difficult for men in general. The discomfort associated with discussing gut issues, when they were deemed sensitive, was reportedly not confined to patients:

> I think just because doctors are medically trained doesn't make them very good at talking to people about sensitive issues, and it can take quite a lot of assertiveness and a long relationship with the GP [general practitioner].

Participants raised a number of issues about their confidence when talking to doctors. For some this was to do with mana and voice. Some felt much more confident at this point in their lives, but this confidence had been hard to build:

> When you're in that survival mode and you're trying to search for yourself or you might not have any mana, but once you find your voice and you feel you have confidence to actually speak up . . . I can do that quite easily now. Whereas before, when you don't have mana or you don't have any probably confidence or self-esteem and all those sorts of things, 'cause you've being spat out of a system, it's hard to speak up, if that makes sense.

Some needed encouragement from trusted friends:

> We're in a . . . club and one of the men was just sitting around the table and having a beer. And he just piped up and he says, "Do you guys go and get a men's check ever?" Everyone's looking around, and going, "What? Hey?" "No, no," and . . . he said, "You need to go once a year and get a check-up, because you know, otherwise it's too late," and all that. I thought about it when I came home and I thought, oh, yeah, he's right. I thought I might go and get one.

> They ran that out of the marae. So that came up and then that had me, because it was real bad at that time for me, and so had me thinking that, you know, I was seeing other Māori men, Pasifika men go and do these tests that maybe, maybe it'll be okay. This will be about a year later of passing blood. I ended up having some courage to go to the doctors.

Others described more explicitly managing what they saw as the hierarchical positioning of medicine, elitism of doctors and the desire not to "expose yourself" within that context. Working out when to go to the doctor was complex and mediated by an array of other considerations, some of which were quite subtle. For example, some participants talked about the ways they had developed an understanding that they should not complain. They recognised the tension between seeming to always have to be well and uncomplaining, and the importance of acknowledging body problems and vulnerability. This seemed especially significant for Māori men:

> We're the staunch ones, the strong ones, the, you know, protect the whānau and so forth, so there can't be anything wrong with us in this, you know, or yeah, if it's something like irritable bowel, then that's something that you just tolerate. I think there is that perception there, and I'm certain it's worse for Māori.

Participants talked about many practical details that might prevent them from seeking healthcare, including pressing family responsibilities and being too busy to take time off work. Others talked about the ways Māori in general (and they themselves) had been poorly treated in and by the healthcare system, leading some to see the health system as a last resort:

> [It is] the ambulance at the bottom of the cliff. So you don't want to go unless something's really, really wrong.

Another said:

> I was also raised, I don't know why, but you're only to go to the doctor if you were seriously ill. So that was something that I was raised on as a young boy, and by listening to, you know, how the system treated our people, my experiences of my grandparents or my mother growing up in this country—so as a young boy, I was raised only to go to the doctor unless you're about to die basically.

Some also directly raised the issue of racism in the system, which manifested through condescension and rudeness:

> Oh, apart from the racism that's out there when you're in the system sometimes, but you find that everywhere in the system. There are some really lovely people in there, but there's still racism in there. I've had it all my life . . . Yeah, just learnt to handle it. Like pause is a great one, if someone's been really condescending and rude, or patronising and all of that, you just pause. Or I'll actually turn and walk away . . .

The intermittent nature of some problems created anxiety as people were not sure if their problem could be so easily investigated if it was not "flared up" at the time of consultation:

> No, 'cause it's, like every time I think about it to go to the doctor, by the time I get in it's like, well are they going to be able to do anything because I haven't had any symptoms for a while?

> I was getting stomach cramps, bloating, constipation—go from diarrhoea then turn into constipation and then nausea . . . It was almost like every two months . . . In the first year I would go [to the GP] every time . . . Often it was hard to get an appointment, so by the time I'd get into them all the symptoms had gone. The response was just, "Right, we've done everything," you know, [the symptoms were] passing over, like that's all that was done.

Being flared up was also a concern, for example, for those who had adopted a gluten-free diet that they felt mitigated their abdominal issues to some extent. To allow for diagnostic biopsy, they would need to be eating gluten. The resulting symptoms can be inconvenient enough to affect one's ability to work, and can be a barrier to diagnosis:

> My problem is I'm a bit worried whether they will be able to take a sample, or whether they actually need it to be flared up, so I don't want to go down that road . . . I want to be able to work.

There are a wide range of issues to do with talking about and acting on gut problems. While some of these may be shared with non-Māori, some of them relate to the ways colonisation continues to have an impact on Māori in ways that have the potential to harm.

Being brushed off and breaking the cycle

Having decided to seek care for a gut issue, participants frequently felt "brushed off", and as a result, their diagnosis took some time. Research shows that Māori experience a different quality of care compared with Pākehā across a range of medical and surgical conditions (Gurney et al., 2020; Mazengarb et al., 2020; Rahiri et al., 2018). Cram et al. (2003) found that Māori patients often needed to be more persistent and assertive to obtain what they needed from the healthcare system:

> [I]t was just shrugged off when I said I had bowel problems, like diarrhoea or constipation, and I had that off and on for years. And it was just shrugged off.
>
> I can remember telling her about it and she said, "Oh, it's just cramp in your stomach." I mean who gets cramp that often in their puku . . . It's quite funny because we talk a lot about how Māori people just seem to be either too whakamā to speak up or being just pushed aside . . . One of my best friends [went with me to the doctor] and she said to the doctor, "I fear the people down here are just getting shoved aside, people not listening to us." You know, she sees it every day and she said, "And I want. . ." She always calls me auntie. She says, "I want auntie to have a scan for her puku." What do they do? They send me a letter. "We'll send you a letter for when you can get your appointment [to see whether she was eligible for a scan]." Yeah, so I just threw it in the rubbish. I thought, how long am I going to sit here . . . to see if I'm eligible to have that scan?

After having felt brushed off for many months of repeat visits and self-treating with medications left over from a sports injury, one participant was cast as a drug seeker. This casting may reflect personally mediated racism as a result of the participant's age, gender and ethnicity, and resulted in this person ceasing to try to access primary healthcare:

> I didn't even go because what stopped me was a conversation that I had with the GP where I asked for tramadol, because it was the only drug where I knew that would numb the pain, and I got a brochure around drug abuse and drug addiction. I never went back after that . . . When I reflect, I think that perhaps raised red flags for them because I'm asking for a drug I'd never been prescribed before . . . from her anyway . . . [this went on for about 8 months] until it [bowel] perforated . . . It's the most painful thing that I've ever had in my life . . . Then within maybe 12 hours of being in hospital, I was told that I was going to have surgery to remove part of the bowel, which would leave me with a colostomy bag.

The cycle of feeling brushed off was broken for the participant above by an emergency hospital admission, but for others it was broken by seeing a different clinician:

> [I thought it was] something I'd picked up [overseas] kind of infection or something. And it didn't really get any better, so I went back again. I thought, this still isn't right, so I went back again. And there was a student there . . . So, I told her, "I've been here several times and it's not right, and I think there's something more going on" . . . And so he got onto it, and I think it was the fact that I'd gone back and there was another person there sort of propelled him to realise that it was more serious.

There were also examples of primary care doctors trying to push the system in unorthodox ways to have people who they were concerned about seen by specialists:

> It wasn't 'til I went to the doctor [a different doctor] recently, where he was quite concerned that this had been going on for so long . . . and I got turned down for a colonoscopy . . . so it sort of was like, nothing can happen now. I can't really do anything more . . . He [the doctor] said to me, "Look, I'll write you out a referral. Just go down there and see if they can see you." . . . And so, I went down the hospital here . . . "Your doctor can't do that. He knows what he's meant to be doing. You shouldn't be coming down here.". . . [Participant went back to work, then home and thought] No, bugger it, I'm going to the hospital . . . I ended up staying in A & E overnight . . . the next day they got me into the CT scan. That's when it come up that about 10 cm of my bowel is inflamed and that's where I got the diagnosis [of diverticulitis]. So that was a lot of relief because it was like, okay, it's not bowel cancer. So the doctor was really good. He went through what it meant.

In some cases, the cycle was broken when symptoms worsened in ways that alarmed a clinician ("red flag" symptoms); such as gagging on food:

> Well, I had bad gastro problems with reflux, and then it got to a point where I was gagging on everything I ate and drank. They kept giving me pills to

> help with the reflux, but it wasn't curing anything. So, I kept going back until they gave in and put a camera down and found what they found . . . It was over a couple of years. But it's when the gagging came on, that changed the whole emphasis, so that's when they probably realised there was something more happening. And to me, I thought there was something wrong right through it. You put your faith in professionals, I suppose.

Feeling brushed off is not necessarily confined to Māori. It may be entirely appropriate for a clinician to suggest watching and waiting, but ideally such watching and waiting should not leave the patient feeling as though they have no ongoing support for their symptoms nor continuing care for their wellbeing. Given the significant inequities in Māori wellbeing and outcomes, it is pertinent to engage an extra level of caution with Māori patients. Māori presenting recurrently with the same (or worsening) symptoms should prompt doctors to reconsider presumed diagnoses, especially if multiple different doctors have been consulted by the patient.

Healthcare relationships in mainstream systems

Though Kaupapa Māori services do exist in many parts of Aotearoa, none of the participants mentioned accessing these. They were therefore using "mainstream" services. It is not the case that all experiences of care were negative. In practical terms, participants who had private health insurance generally reported smoother trajectories and more supportive relationships with healthcare staff. One participant explained how important it had been that their workplace provided private health insurance, which made them feel well looked after:

> Oh they're really, really good with family comes first and your health, your wellbeing . . . They're all really big on that, there's a big emphasis on whānau . . . They're an old company . . . been around for a long time . . . They've got quite a few Māori . . . working for the company . . . a lot of Filipinos, so across the board really . . . That's the other thing with this company, they've set us up. I get free medical care insurance.

Yet private health insurance is unaffordable for many, and several commented that they had to stop their insurance due to cost. Only 20% of Māori adults, as compared with 37% of Pākehā adults, have private health insurance (Ministry of Health, 2016).

As found by other authors (Cram et al., 2003; Graham & Masters-Awatere, 2020; Kerr et al., 2010; Palmer et al., 2019), relationships and meaningful connections with healthcare providers were especially important to participants. Participants lamented how primary healthcare providers had changed in ways that sometimes made it hard to develop helpful relationships with a GP:

> I actually knew our doctor, I knew their name, knew their whānau. So, when we talk about that continuity of care, we actually knew them and they knew us. They knew our whole family. Whereas it's a lot different now, where I have to go and I actually don't really know that person. I do know in that primary care space . . . it's a really time-limited consult, when sometimes, also us, being Māori, sometimes we have multiple needs.

> In the day, you went there and you could tell them everything. But now, "Make another appointment." Another $30 or something like that, you know . . . it's about trusting, when you talk with people, trusting them. How can you if you only have 15 minutes? Well, I don't even know the person. I'm not coming back.

Several participants had surgery for their gut condition. One recalled good experiences with being consulted about what they would like done with removed body tissues; however, no kaumātua support was available in hospital:

> I did mention that in there, but, "Well, do you want someone?" "No, no, no. I just thought you might have a service." It's a huge public hospital here, I'm sure I'm not the only tanned person in there.

Another participant found the communication following surgery extremely poor, to the extent that they did not know they had a diagnosis of diverticulitis when they left hospital. No assistance was provided with emotionally adjusting to the colostomy, though they were offered assistance with its physical care:

> I didn't know how to manage it psychologically. Like there's no kind of discussion around that aspect of what's happening in your hinengaro . . . 'Cause suddenly kakā from my stomach is now, like it bulges through your clothing . . . which I really struggled with.

Cram et al. (2003) found that Māori valued doctors who took the time to get to know them and created an environment in which they felt respected. In spite of the problems identified above, many (though not all) of the participants, had eventually identified doctors and other healthcare providers who better met their needs. Participants reported positive relationships with both Māori and Pākehā doctors and other allied health practitioners, though some much preferred Māori healthcare providers:

> It hasn't been until I've seen a Māori GP that the things that I've been talking about have been taken seriously . . . It's felt like she's the first GP that's ever really got me and that I haven't had to become exasperated with to be heard and for steps to be taken. Which has felt really validating.

People especially valued not feeling rushed, that their concerns mattered and that they would be able to be involved in decisions about what any next steps might be:

> So, [he] sat down with me, and this is the first GP I ever found who's done this and asked, "How do you actually feel?" . . . So, he took the time to do all that. So, I've never found a doctor who's done that . . . when you've got some underlying issues, and a lot of them, and it's not easy. You do need to take time to actually go through them, and [he's] the one GP that I've found who's done that.

> They listened to what you said when they asked a question, 'cause sometimes they don't, but mine all did, and they answered questions and they allowed me to have my say when I wanted to—like, "Oh I'm not sure that I'll have that or not. I'll think about that." And they didn't look surprised.

> But when I was there they were very welcoming and standard and just did what they did and were, compassionate and very thorough . . . Yes, and he even rang after hours to check in to see how things were, and if he got results back . . . So that was the first time ever from a GP, ringing Sunday evening to see how things were.

Participants valued staff who took the time to ask about pronunciation of names, for example, thus showing some humility. But the ways relationship and respect played out were not always straightforward. One participant valued the ability to overtly argue with her doctor, which is in many ways a step on from just being involved in decisions about care that are framed by the clinician:

> I would always want to do the more natural way of doing things and he'd go, "Oh." I'd be like so frustrated and I think the reason I stayed with him 'cause we could have good rows . . . I frustrate him. Banging his hand on the thing and I say, "No, I'm not going there." He goes, "But you could have that solved. I'd have it solved for you. You know, this year," and I said, "Well, you can get seaweed and use it as a shake too," and he goes, "Augh." . . . Yes, he's been brilliant.

Participants had often experienced lengthy periods with less-than-ideal care as they tried to resolve their gut issues. There are some challenging aspects to some of the experiences noted here. For example, having a known and trusted family doctor was viewed as positive. But some people felt this trust was breached when they received delayed diagnoses with conditions that might have had better outcomes if diagnosis (and therefore treatment) had occurred earlier. Seeing a different clinician, even though they might not yet be known and trusted, acted like a circuit breaker in some cases and generated referrals to secondary care. Given the importance of relationships with a known and trusted clinician, making this shift, and seeing another clinician, would be a hard decision to make. In some cases, however, changing clinician could lead to a much more satisfactory and supportive relationship. Shifting clinicians is, of course, somewhat harder to do in rural and underserved areas.

Discussion

To summarise our results, three themes identified from participants—talking about the gut and deciding to seek care, being brushed off and breaking the cycle, and healthcare relationships in mainstream systems—contribute to our knowledge about how Māori understand the gut and navigate the health system when experiencing gut symptoms and disease.

Successfully recognising and articulating gut issues and navigating healthcare is key to early diagnosis and treatment, as is having access to a health system with the responsiveness and capacity to meet Māori needs. Participants identified many barriers to coming forward with gut symptoms, some of which are unsurprisingly rooted in deep-seated mistrust of what and who the mainstream health system is for, and the difficulty of engaging and protecting their mana in that system. Māori can find the healthcare system disempowering and dehumanising, due to staff failing to attempt to build trust (through whanaungatanga) and provide mana-enhancing care, the brevity of GP appointments, and the lack of discretion and warmth in clinical settings (C. Harris et al., in press). The accusation of drug-seeking behaviour experienced by one of our participants in relation to managing gut pain correlates with a finding by Ellis et al. (2024) that 40% of their sample of Māori women were accused of drug-seeking behaviour in relation to pain from endometriosis. The experience of racism affects engagement with the health system and contributes to unmet need (C. Harris et al., 2024).

Our results have focused predominantly on primary care. This is not surprising as primary care, in whatever form it takes, is the first point of contact with the health system in Aotearoa, through which people must pass prior to being referred for the investigations required to diagnose gut disease. It is therefore a crucial nexus at which people may be delayed. It is not the case, of course, that everyone who presents with gut symptoms must automatically be referred on for further investigations. In many cases further investigations are not warranted and can themselves carry risks, and so referrals need to be justified (Arora et al., 2009; Esteva et al., 2013; Kyriakides et al., 2022). There are, however, many examples in our research of Māori participants with problematic issues accessing appropriate care, delayed diagnoses, and significant health and wellbeing burdens that could have been reduced or avoided.

Several authors (Ramos Salazar, 2018; Wright et al., 2007) have argued that people should self-advocate for the care they think they need, and in fact, a number of the participants also said this. We are concerned at placing the burden fully on patients and an individual's health literacy (one's knowledge of how to access, understand and use information to optimise health), which fails to acknowledge health system factors such as power relations (World Health Organization, 2024). We acknowledge the potential usefulness of developing resources so patients may better advocate for themselves. However, this should also be accompanied by a focus on organisational health literacy and the responsibility of organisations such as health services to empower individuals with the skills and knowledge to navigate health (U. S. Centers for Disease Control and Prevention, 2021). R. Harris et al. (2024) found that Māori women receive variable but often unsatisfactory information about contraceptive options and gynaecological procedures from healthcare providers, and that sexual health information was rarely acquired through reliable sources. The authors concluded that services need to ensure Māori are well informed about their sexual health and treatment options. This need extrapolates to other areas of healthcare and is important in improving cultural safety.

Attention to cultural safety in healthcare is not new but often falls short of achieving the goals intended. Part of this failure is attributed to the ways the concept has been depoliticised (Curtis et al., 2019; Lokugamage et al., 2021) by ignoring or marginalising discussions of power and disempowerment. This was a fear held by the concept's originator, Irihapeti Ramsden, and discussed in her doctoral thesis (Ramsden, 2002). Depoliticisation can take the form of softening language by using terms such as cultural "awareness", "sensitivity" or "competence" (Lokugamage et al., 2021). While these terms may not seem problematic, they can serve to place the focus solely on what a practitioner might know, rather than also attending to how care is received. That is, these approaches do not address whether care feels culturally safe to the recipient (Ramsden, 2002).

Frameworks, such as the Hui Process (Lacey et al., 2011) and the Meihana Model (Pitama et al., 2007), originally developed for use in medical student training, may help closer movement towards culturally safe healthcare at the practice level. The Hui Process provides a structure designed to do more than give a tokenistic guide to a clinical consultation. The structure places strong emphasis on whanaungatanga to build trust. This includes greeting and making connections, incorporating relevant self-disclosure on the part of the clinician, attending to the clinical matter at hand and concluding the encounter with attendant next steps (Lacey et al., 2011). This first step of this process is particularly important and sets the tone for what else may be achieved in the consultation. The Meihana Model works alongside the Hui Process to better understand individual Māori beliefs, values, and current and past experiences, including within the health system (Pitama et al., 2007). This latter model allows for a more thorough appreciation of a patient's situation (mentally, physically, spiritually, historically) beyond just their symptoms. Approaches like this allow practitioners, in the case of the gut, to delve into how people understand the gut as well as how aspects such as institutional racism may inhibit care seeking. Gaining knowledge such as this can help clinicians tailor interactions in ways that better meet needs and increase comfort with and in clinical interactions.

At the level of policy and health system organisation, the disestablishment of Te Aka Whai Ora, the Māori Health Authority, which was a move towards Māori control of Māori health, is deeply concerning and fails to honour te Tiriti o Waitangi obligations on the part of the government (Pitama et al., 2024). Also concerning is the current government's rhetoric that health services should be based on need, not "race". The evidence clearly states that "ethnicity is a strong marker of health need in New Zealand and is an evidence-based way of targeting healthcare resources" (Loring et al., 2024, p. 11). A recent decision to reverse the age of bowel cancer screening for Māori from age 50 to 58 is a step backwards for Māori health and will continue to exacerbate health inequity (Royal Australasian College of Surgeons, 2025).

Decolonising healthcare and systems to more adequately and equitably provide care to those with gut symptoms requires moving beyond business as usual with a dash of "cultural competence" towards addressing institutional racism in the New Zealand health system.

Glossary

Aotearoa	New Zealand
hauora	health
hinengaro	mind, consciousness
kai	food
karakia	prayer(s); chant(s) and incantation(s)
kakā	inflammation
kaumātua	Māori elder
Kaupapa Māori	Māori based topic/event/enterprise run by Māori for Māori
koha	gift, token, pledge
mana	authority, status
Māori	Indigenous peoples of Aotearoa
marae	tribal meeting grounds
mihi	speech of greeting, acknowledgement, tribute
nono	anus
Pākehā	a person of predominantly European descent
puku	stomach, centre
tangata whenua	people of the land
te Tiriti o Waitangi	the Treaty of Waitangi: founding document establishing rights, responsibilities and relationships between the Crown and tangata whenua signed 6 February 1840
Te Waipounamu	the South Island of New Zealand
whakamā	shy, embarrassed
whānau	family; nuclear/extended family
whanaungatanga	relationship, kinship, sense of family connection

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