

The cultural load of Māori doctors in Aotearoa New Zealand: unrecognised labour - a 'colonial tax'

David Tipene-Leach

dtipene-leach@eit.ac.nz

Eastern Institute of Technology

Shirley Simmonds

Independent Kaupapa Māori researcher

Helena Haggie

Tū Tonu Medical Centre

Virginia Mills

Association of Salaried Medical Specialists | Toi Mara Hauora

Tania Riddell

Health New Zealand | Te Whatu Ora

Marnie Carter

Allen and Clarke

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Abstract

Background

Cultural load refers to the extra, largely unrecognised demand placed on Indigenous and non-white professionals in the workplace. The nature of this load among Māori doctors, and its implications for their wellbeing, their retention, and the New Zealand health system, remain undescribed in the peer-reviewed literature.

Methods

A mixed-methods study grounded in Kaupapa Māori methodology combined focus groups, interviews and an online survey. Qualitative data from 23 Māori doctors across five medical specialties were analysed thematically and 96 Māori doctors completed a survey which was analysed descriptively.

Results

Māori doctors reported becoming the default cultural expert and the 'Māori representative' for their workplaces, often in unsafe situations without recognition, compensation or institutional support. They labelled it the 'colonial tax'. We grouped this labour into four categories: advocacy for Māori patients navigating services; tokenistic participation on committees; personal provision of cultural infrastructure; and the teaching of cultural safety competencies. Survey data showed that 67% spent five or more hours per month on top of their clinical load on such work and 20% spent more than 15 hours per month. Only 8% received any financial recognition. Stress was reported by 73%, a feeling of burnout by 47%, and over half (52%) rated personal impact as moderate or heavy. Some participants also reported feeling complicit in perpetuating health systems that produce inequitable health outcomes for Māori. However, responsibilities arising from the community were experienced as meaningful obligations rather than as burdens, and 75% were pleased to take these on.

Conclusions

Māori doctors perform unrecognised and uncompensated labour that substitutes for functions the health system would otherwise have to resource, and in doing so sustain the system that continues to produce inequitable outcomes for Māori patients. Their recognition of complicity in this connects cultural load to moral injury. We set out seven system-level actions, each naming the actors responsible. Because they shift structural power and resources towards the Māori medical workforce, addressing the colonial tax is a decolonising as well as a workforce measure. Change must lighten institutional load without eroding the community connection that sustains resilience.

Background

Cultural load refers to the additional, often unrecognised, professional responsibilities that Indigenous and/or other non-white professionals face in their workplace. The concept itself first appeared in 1994 as *cultural taxation*, describing the extra burden placed on ethnic minority scholars (the authors' term) in the United States [1]. It is now often called the *minority tax* [2]. A related concept is the *gratitude tax*, that is, the expectation that these scholars, now labelled as under-represented minorities (URM), should feel grateful to their institutions for being given the chance to work there [3]. Other research documents how non-white academics in the US are repeatedly asked to take on diversity-related service work that white colleagues are not [4], while the term *Black tax* captures the psychosocial toll of Black and Brown higher education professionals working in such environments [5]. These pressures also affect career progression as US faculty must meet the expectations of competitive research output while meeting diversity expectations [6, 7, 8]. They also face discrimination while being expected to educate colleagues about systemic racism [9, 10, 11].

These dynamics extend beyond American academia. A scoping review from Australia described discrimination experienced by CALD (culturally and linguistically diverse) health practitioners and how workplace hierarchies sustain these barriers [12]. The Indigenous Weenthunga Health Network later reframed this burden as *colonial load*, arguing that responsibility for cultural and equity work should not fall disproportionately on Indigenous staff [13]. This reframing is conceptually important, as the term cultural taxation identifies the cost to an individual of such additional labour, whereas colonial load identifies colonisation as the structural origin of that burden, and repositions responsibility from the Indigenous worker to the institutions and systems that colonial legacies have shaped. In Aotearoa New Zealand,¹ similar pressures are reported among Māori teachers required to educate non-Indigenous colleagues [14], and Māori scientists, who describe how *he aronga takirua* (a cultural double-shift) contributes to stress and burnout [15]. Although cultural load is well described internationally and has been increasingly recognised among Māori professionals, no peer-reviewed study has examined such load among Māori doctors.

Alongside Indigenous peoples across the globe, Māori experience inequitably poor health outcomes [16, 17] due to systemic discrimination, socioeconomic marginalisation and colonial legacy [18, 19] as well as New Zealand's failing health system [20]. Māori were also markedly under-represented among medical professionals in 2024 making up 5.1% of registered doctors versus 17.8% of the general population – although this is increasing, that is, up from 3.3% in 2016 [21, 22]. In Aotearoa New Zealand Māori are entitled to health outcomes equal to non-Māori, an obligation the Crown² carries under te Tiriti o Waitangi,³ and one the Waitangi Tribunal⁴ affirmed as a Treaty guarantee in its 2019 Wai 2575 report Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry [20].

Māori doctors, through their national organisation Te ORA, (the Māori Medical Practitioners Association), were an 'interested party' to this inquiry with its own Wai 2499 claim, and much of their evidence was about inequitable Māori health outcomes and the lack of cultural safety in New Zealand health services [20]. Over the past decade Te ORA has led a work programme with the (MCNZ) of New Zealand around the definition and implementation of cultural safety in medical care [23, 24, 25]. In an associated project with the Council of Medical Colleges (CMC), Te ORA designed a cultural competence and cultural safety framework for vocational medical training [26, 27, 28]. While the medical profession has begun to grapple

with expectations for culturally safe care, it has not yet addressed how cultural safety is to be implemented. Cultural load on Māori doctors has emerged as a persistent theme, particularly around how cultural safety might be addressed in the teaching and training programmes of the colleges [27, 28]. To better understand cultural load among Māori doctors, Te ORA undertook this research project with New Zealand Health Quality and Safety Commission (HQSC) funding, and this paper is based on the commissioned report of that work [29]. The research aimed to describe the nature of cultural load experienced by Māori doctors in the workplace, to examine the responsibilities arising from within their own communities and how these differ from professional cultural load, and to identify the implications of cultural load for Māori doctors' wellbeing and retention, and for the New Zealand health system.

Methods

This study was grounded in Kaupapa Māori (Māori ideology), a methodology which centres Māori experience and is conducted by Māori, for Māori and with Māori [30]. The mixed method design combined qualitative focus groups and interviews with a cross-sectional online survey to explore the nature and the extent of cultural load experiences among Māori doctors. This research arose from an ongoing concern raised by Māori doctors and Te ORA around the disproportionate work-related cultural responsibilities placed on them by the health system. Consistent with the Kaupapa Māori principle that research should benefit Māori, the findings were intended to advance Māori doctor wellbeing and drive systemic change and Māori health equity. Reporting of this study has been mapped against the Consolidated criteria for strengthening reporting of health research involving Indigenous Peoples (CONSIDER) [31]. The completed mapping is provided as Additional file 1.

Research team

The research team was Māori doctor-led. Kaupapa Māori research expertise was held by two authors and three members of the team were Māori doctors. The two authors who are not Māori contributed research, policy and employment relations expertise and have worked in this research consortium on Te ORA's cultural safety work programme with the MCNZ and the CMC. Māori researchers held primary responsibility for design and conception of this research and the focus groups and interviews were conducted by two experienced Māori researchers. The findings were grounded in the cultural and political realities of Māori doctors' experience and were analysed in a fashion consistent with the Kaupapa Māori methodology underpinning the study.

Participants and Māori processes

All those who participated in this study were doctors who identified as Māori, and so the knowledge generated was drawn from within the group that the research concerns. They took part as members of Te ORA, the organisation sponsoring this research into the working conditions of its own members. Tikanga (Māori processes) were observed throughout the data collection. Focus groups and interviews were opened and closed with karakia (Māori prayer). Te reo Māori (the Māori language) was incorporated into

these engagements, in a manner that matched participants' use of the language. No koha (reciprocal gift) or other payment was provided.

Recruitment

Māori doctors were recruited through Te ORA, the national Māori medical professional organisation, from five medical specialties: general practice, psychiatry, general medicine, surgery, and public health. For the qualitative component, a whanaungatanga (relationship centred) recruitment process was used [32, 33], whereby a Te ORA member from each specialty college was contacted and asked to purposively select four to six colleagues representing a diverse range of age, gender, and career stage. These included doctors in prevocational training, those in vocational training, and those who had attained fellowship. Before they consented to participate in the research, participants had been supplied with an information sheet and a copy of the questions that were to be covered. For the quantitative component, the survey was distributed via email in the Te ORA e-Pānui (newsletter) to all Te ORA members, who Te ORA records put at approximately 300. At this time there were 1020 Māori doctors registered with the MCNZ [21].

Data Collection

The initial list of questions was developed by the research consortium including researchers, and key Te ORA and HQSC persons. The bespoke survey instrument was developed by the same group with questions tailored to specific areas of interest for the research. We did not use or adapt existing instruments, given both the paucity of previous research in this topic and the desire to explore issues specific to the Aotearoa NZ context. Although there was no formal piloting of the survey instrument, we did test the survey for flow, logic, order and readability of questions with members of the research consortium.

Qualitative data were collected through semi-structured focus groups and individual interviews conducted online between September 2023 and March 2024 using Zoom. All sessions were opened with karakia, mihihihi (welcomes) and whakawhanaungatanga (full group participant introductions). The interviews were conducted by the Māori researchers (DTL and SS). Quantitative data were collected via an online survey hosted on SurveyMonkey and distributed to Te ORA members through the organisation's March and April 2024 email newsletters.

Both the interview guide and the survey instrument were designed around an a-priori distinction between two forms of cultural load: professional cultural responsibilities arising from the workplace, and community cultural responsibilities arising from whānau (family), hapū (wider kinship groups) and broader Māori community relationships. This distinction was conceived by the Te ORA-based Māori doctors and the research team prior to data collection and was built into both the qualitative and quantitative instruments.

The interview schedule explored participants' experience of cultural load, the nature of additional responsibilities they undertook, the comparison of cultural load between workplace and community contexts, the impacts on their personal and professional lives, and potential strategies for addressing

challenges. All sessions were audio-recorded and transcribed in full, with participants' consent. Our interviews followed the question line that had been provided beforehand, with probing questions used to draw out details. Participants were offered their interview notes and transcripts to check, correct or amend before analysis.

The survey also made the distinction between professional cultural load arising from the workplace, and the responsibilities arising from family and community. The questions covered the extra roles Māori doctors played in both contexts, the time they spent on this extra work, their attitude to the imposition of that work, the impacts it had upon their lives and their whānau, and their suggestions for mitigating the negative impacts. The survey was estimated to take 10 minutes to complete and included both closed quantitative questions and open free-text response options. To preserve anonymity in a small workforce, we did not ask for specialty in the survey but we did ask for an indication of career stage.

Analysis

The analytical process was conducted within a Kaupapa Māori framework. The Kaupapa Māori methodology underpinning the study shaped interpretive decisions, with the Māori-led research team's cultural knowledge and positioning informing how findings were framed and understood. Qualitative data analysis was conducted using NVivo software. Transcripts were coded by two team members (SS, MC) using an open coding approach, allowing themes to emerge inductively from the data. This inductive coding operated within the a-priori distinction between the professional and the community-derived cultural load that was built into the interview schedule and survey. A constant comparative method was employed whereby each new piece of data was compared with previously coded material to identify patterns, similarities, and differences across participants' experiences. Through an iterative process of coding, reviewing, and refining, three members (SS, MC, DTL) of the research team developed a thematic framework capturing the key dimensions of both types of cultural load. Consensus on the final thematic structure was reached through full team discussion and this was taken back to the research consortium. Findings were also presented to a Te ORA conference in 2024, and feedback from that hui informed the final report [29].

Free-text responses from the survey were integrated into this thematic analysis to provide additional depth and context. Quantitative survey data were analysed descriptively in Microsoft Excel. For this paper, the research team extended the analysis undertaken for the report to show how doctors' experience of cultural load mapped to specific institutional functions and the continued operation of an inequitable health system.

Results

Interview participants and survey respondents

A total of 23 Māori doctors participated in the qualitative interviews. Data were collected during four focus groups, each with participants drawn from different vocational colleges. Five general practitioners, five

internal medicine physicians, six public health physicians, and five psychiatrists took part. Because we were unable to gather a group of surgeons together within our project timeframe, we conducted two individual interviews of senior surgeons (Table 1a).

Table 1
a: Characteristics of focus group
and interview participants, by
specialty (n = 23)

Specialty college	n	%
General practice	5	22
Internal medicine	5	22
Public health	6	26
Psychiatry	5	22
Surgery	2	9
Total	23	101

Percentages are rounded to the nearest whole number and sum to more than 100.

All sessions lasted between 60 and 90 minutes. Our participants covered most of the questions they had been provided with beforehand in a free-flowing, open fashion and the facilitators only stepped in with question probes to draw out details from time to time. Participants appeared both keen and relieved to be able to talk about their experiences. There was no appreciable difference in responses between interview participants based on their medical specialty, although there are some differences based on career stage which are noted in the subsections that follow. To protect privacy, quotes are attributed only by source (focus group or survey) and career stage (Fellow, Registrar). All Māori words in the quotes are translated.

A total of 96 respondents completed the online survey, representing a response rate of approximately a third (32%). Most of the respondents (70%) were Fellows (senior doctors); 20% were Registrars (in specialty training) and the remainder were RMOs (resident medical officers) or medical students (Table 1b).

Table 1
b: Characteristics of survey respondents, by
career stage (n = 96)

Career stage	n	%
Fellow	67	70
Registrar	19	20
RMO / non-training registrar	8	8
Medical student	2	2
Total	96	100

RMO = resident medical officer.

Reporting of survey data includes: description of all participants; time, impact and experience of professional cultural load; nominated training priorities; time, impact and experience of community-derived responsibilities. These are presented in the Tables 1 to 4 that follow. For each survey item, both the number of respondents (n) and that number as a percentage of respondents to the item are reported. Percentages are rounded to the nearest whole number.

Professional Cultural Load

Professional cultural load was experienced as additional duties and expectations placed on Māori doctors in the workplace because they were Māori, regardless of their actual cultural expertise or interest in these roles. One doctor expressed it this way, “We call it the colonial tax. It means the other mahi [work] that we have to do that’s not part of the stuff that we love. Any extra work above and beyond my duties that I’m employed for” (Focus group, Fellow). This phrase was already in use among some Māori doctors and *the colonial tax* became the title of the Report [29]. Within this a-priori category, professional cultural load was expressed through several recurring themes that emerged from the data, each described below.

Māori as default cultural authority

Māori doctors were routinely treated as the default authority on Māori language, culture, and health matters within their workplaces, and were expected to represent “all things Māori.” As one doctor explained, “I often get asked ‘we need someone with a cultural lens’, or ‘can you provide some advice around tikanga [Māori customs] on this pathway?’” (Focus group, Fellow).

Expectations extended well beyond formal or ceremonial roles, with doctors frequently asked to undertake cultural tasks outside their expertise or without preparation, for instance, “(I am) expected to fill roles such as Māori data sovereignty advisor, despite my lack of expertise” (Survey respondent, Fellow). Another described being asked to perform cultural duties in unsafe contexts: “One of the most challenging things I

have faced is turning up to hui [meetings] and being asked by non-Māori to do a karakia [Māori prayer] and then have to sit through a barrage of racism. It's offensive" (Focus group, Fellow).

Many doctors also described discomfort when expectations exceeded their own cultural knowledge, particularly those with limited exposure to traditional practices: "I'm fortunate enough to have the reo [Māori language] component and some understanding of tikanga [Māori customs] but with that comes its own responsibilities. But I wonder how some of my other colleagues feel when they're getting these tono [requests] and they're not comfortable with that" (Focus group, Fellow).

Doctors were also frequently appointed as the sole Māori representative on committees or boards, often late in project processes and in tokenistic roles. As one noted, "If I turn up and see that I am the only Māori person there, this is a red flag and I'm already unsafe" (Focus group, Fellow). Consultation around projects and academic exercises most often occurred at the final stages of projects, leaving Māori doctors to retrospectively identify fundamental gaps: "I was the Māori voice to review this document and I had to start my review with 'this is not consultation with Māori, no Māori have been involved in this'" (Focus group, Fellow). Some participants also described "Māori shopping", where organisations sought alternative Māori opinions until receiving their preferred responses.

Māori as clinical advocate and system navigator

Many doctors described carrying disproportionate responsibility for Māori patients, often undertaking additional work to ensure safe and effective care within systems they viewed as difficult for Māori patients to navigate. As one explained, "I probably take on extra work for my Māori patients in order to provide good quality treatment and continuity for patients who might not be able to navigate the health system effectively" (Survey respondent, Registrar).

This advocacy frequently occurred alongside normal clinical duties: "You do your clinical ward rounds and then you do the rounds of whānau [family] and friends... those who are being mistreated by the service... it's just an additional clinical load" (Focus group, Fellow). This advocacy functioned as informal system navigation and mediation that often compensated for wider system shortcomings, particularly for Māori patients.

Māori doctors as cultural safety educators

The growing recognition of the need to address health inequity and recent cultural safety reforms by the Medical Council of New Zealand and Council of Medical Colleges have intensified the load on Māori doctors. They have been positioned by default, as the source of cultural safety and Māori health knowledge for their non-Māori colleagues. Many were asked to take on formal teaching roles without preparation or institutional support: "[I was] automatically given the job of teaching the Māori health segment in registrar teaching, with no indication of what the specific goals were for the session" (Survey respondent, Fellow).

Even when doctors had relevant skills, they questioned why they were being asked to teach cultural safety: "Someone approached me and said, 'can you come and talk to us about cultural safety.' I have some skill and knowledge in that area. But I'm of two minds about it, because of how much I would have to invest in it

to teach them, rather than them contracting someone to come in and roll it out” (Focus group, Fellow). This teaching role extended to Māori language tuition as well: “I love it that my colleagues love it. But it's an extra thing. I coordinate, I provide a lot of the teaching, and I get a lot of questions. That's all extra” (Focus group, Fellow).

But even changes intended as progress can generate new forms of load. As one participant observed, “We get all excited and say ‘I would love to do a karakia [Māori prayer] at the start of this meeting’ because we don't normally get to do karakia and that's supposed to be progress - but it inevitably falls back on our people to do that” (Focus group, Fellow).

Cultural load is imposed early in career

Cultural expectations were often placed on Māori doctors from the earliest stages of training. One participant recalled being asked during ward rounds as a junior doctor to explain Māori health issues to other colleagues. “On the ward round as a junior, I remember being turned to by one of the surgical consultants and being told, ‘now, tell me all about Māori health.’” (Focus group, Fellow). Others described being asked to run Māori-focused clinics before they felt clinically confident: “I get asked, ‘can you do a Māori clinic and we'll just put all the Māori patients in your clinic?’ But you don't necessarily have the confidence in your clinical skill to back that up” (Focus group, Registrar).

Impacts of cultural load

Table 2
Time, impact and experience of professional cultural load, survey respondents (n = 96)

Item	n	%
Hours per month on professional tasks associated with cultural load		
0–4 hours	32	33
5–8 hours	24	25
9–12 hours	13	14
13–15 hours	8	8
More than 15 hours	19	20
Impact on self and whānau		
No impact	8	8
Minor impact	38	40
Moderate impact	34	35
Heavy impact	16	17
Experience of cultural load		
Pleased to take on cultural load	51	53
Cultural load causes stress	70	73
Feel burnt out from cultural load	45	47
Acknowledged for additional cultural responsibilities	44	46
Financially compensated for cultural work	8	8
Receive good support for cultural responsibilities	19	20

High time burden and little or no compensation

Survey data showed substantial time commitments on cultural load. One fifth of survey respondents (20%, n = 19) reported that more than 15 hours per month were devoted to cultural load tasks, that is, nearly 4 hours extra work each week. Just under a half (42%, n = 40) reported 9 hours or more per month and over two-thirds (67%, n = 64) reported 5 or more hours per month (Table 2). These are significant loads in a busy clinical work schedule, and as one interview participant noted, “Probably, there's not been a weekend for the last couple of years that I haven't done four or five hours work on a Saturday and four or five hours work on a Sunday. And it's not clinical, it's all the other stuff” (Focus group, Fellow).

A very small proportion of survey respondents (8%, n = 8) reported that they received additional payment for these responsibilities. As one doctor explained in their interview, “Because we care, we end up doing

everything in the organisation that's got anything to do with Māori. Suddenly the role that you're employed to do is fattened with all this other stuff" (Focus group, Fellow). And a request for compensation was resisted with, "refusals, barriers, anger and other emotional transference" (Survey respondent, Fellow), reinforcing workplace expectations that such tasks would be undertaken without formal recognition.

Stress, burnout and workforce consequences

Survey responses indicated widespread psychological impacts. Table 2 shows nearly three quarters (73%) of participants reporting stress associated with cultural load and nearly half (47%) labelling it burnout. The cumulative weight of this load was distressing and isolating. As one participant said, "This work is near to breaking my spirit" (Focus group, Fellow), and another, "I am often a sole voice fighting against an overwhelming tide of racism and bigotry" (Focus group, Fellow).

Over half of survey respondents (52%) reported a moderate or heavy impact on their personal life and whānau due to professional cultural responsibilities (Table 2), with much of this work falling outside normal working hours. "Most work happens after hours. The kids don't see this as Māori work, they see it as Mum being in the office away from family" (Survey respondent, Fellow).

And the workforce consequences were at times, quite direct. For one participant, this strain led to reconsideration of their future in medicine, "I felt disenfranchised about medicine and had thoughts about leaving the field. I felt really disillusioned. Those are uncomfortable and horrible feelings to have, but they do come when cultural loading gets to the point of burnout" (Focus group, Fellow). Another participant left the hospital system, "I was extremely fed up with not getting paid to do work that is not appreciated. I quit in frustration" (Focus group, Fellow). A wider observation was that, "The hospital is burning out all the Māori workers and they are leaving to Australia and private" (Focus group, Registrar).

Lack of recognition and negative career impact

Despite being relied upon for cultural expertise, doctors commonly reported that their contributions were undervalued or ignored: "Sometimes I say, 'well, actually, I don't agree with that. This is my recommendation.' But then you look at the paperwork later and only snippets are taken or it's not heeded" (Focus group, Fellow). Cultural work was also seen as less valuable than clinical activity and missed career opportunities were reported, "I am not considered competent outside of te ao Māori [the Māori world] and I have been overlooked for other roles" (Survey respondent, Fellow). The survey confirmed the scale of this: while just under half (46%) felt some acknowledgement for their additional responsibilities, only one in five (20%) felt genuinely supported in carrying them out (Table 2).

Purpose and passion

Despite the time load, the lack of compensation or support, burnout and distress, the impact on career, and limited recognition, over half (53%) of our survey respondents reported that they were pleased to take this cultural load on and be of use to their profession and their patients. This work they said, aligned with their purpose and rationale for entering the profession. For instance, "My reason for becoming a doctor was for Māori. And so you are already going with that load because that's your passion. So to me, it's an expected part of my mahi [work] and I am mostly okay with that responsibility" (Focus group, Fellow).

Burden and complicity

Yet for many, the load carried a deeper cost, with some Māori doctors describing emotional strain from working within systems they believed frequently failed Māori patients: “You see poor care happening all the time, and that moral injury load of having to work in that system is overwhelming” (Focus group, Registrar). More starkly, one named the structural source of that injury, “It's knowing what the best thing to do is, but not actually being able to do that because of the systems and the resources that you have access to. I think that's what I experience a lot as a Māori doctor, this kind of cultural moral injury where I'm working in this racist structure” (Focus group, Fellow). Some went further, naming their discomfort as feeling complicit in sustaining those harmful systems, “...and by continuing to prop it up, we give it validity and have become part of the problem” (Focus group, Fellow). This topic of moral injury was raised spontaneously by participants rather than prompts by the facilitators and it emerged from more than one focus group.

Māori doctors' management of cultural load

Pushback and boundary setting

More experienced doctors described learning to limit or refuse additional cultural responsibilities in order to avoid burnout. As one participant explained, “There's so many invitations that you do, you end up having to be quite selective. Because otherwise you end up spread too thin, you might end up resenting it” (Focus group, Fellow). Decisions about accepting requests were often based on whether engagement would genuinely influence outcomes, with some participants negotiating conditions to ensure their contributions were meaningfully implemented. “I put really tight conditions so that they can't say ‘we've now got the approval of Māori’. If I give you feedback, how is my feedback going to be implemented?” (Focus group, Fellow).

Peer support networks

Support from other Māori doctors was described as the most reliable coping strategy. “I love our brown boys' network ‘cause I don't have an old boys' network from med school” (Focus group, Fellow). Informal networks provided advice, mentoring, and shared knowledge about how to manage difficult committee or organisational environments. “We've got a bit of a list of black marks against various committees” (Focus group, Fellow), was one line of protection. Tuakana-teina [older-younger] mentoring relationships were particularly important in helping less experienced doctors develop confidence to decline requests and prioritise clinical development, “and so he gave me permission to refuse some of these things” (Focus group, Fellow).

Non-Māori allyship

Some participants described supportive non-Māori colleagues who actively worked to reduce inequitable expectations and redistribute cultural responsibilities more fairly. One participant recalled such a colleague saying “... ‘hang on a minute, when there are so few Māori around, you can't expect that they are going to do that’ and would bring others around to support us” (Focus group, Fellow). Such allyship, however, was not

widespread, and many doctors experienced silence from colleagues when confronting racism or excessive cultural demands in their workplaces.

Four categories of cultural load

We grouped the above themes into four categories of cultural load, that is, four distinct categories of labour. These are: advocacy for Māori patients navigating services that are complex and unwelcoming at a personal level and systemically, produce inequitable outcomes; tokenistic participation on committees which most often require some appearance of inclusiveness and outward demonstration of cultural responsiveness; personal provision of cultural infrastructure for institutional events and clinical processes through karakia, mihi and tikanga guidance; and the teaching of cultural safety competencies recently mandated by MCNZ, to colleagues.

Mitigation strategies suggested by Māori doctors

In the survey, respondents identified several strategies that could help reduce or better manage cultural load. Survey respondents were asked directly about training priorities, and their responses are summarised in Table 3. Respondents could select more than one option. Te reo Māori me ōna tikanga (Māori language and customs) was the most strongly endorsed priority, selected by over four in five respondents (81%), reflecting that doctors are routinely expected to lead and teach in these domains while often lacking adequate grounding in them. Governance was the second most endorsed priority (70%), with management training selected by over half (56%). This is consistent with qualitative accounts of being placed on committees and boards early in careers without adequate preparation and performing similar roles in community organisations. Life coaching and mentoring skills were identified by nearly half of respondents (49%), directly echoing the experiences described in the preceding subsections.

Table 3
Training priorities selected by survey respondents from a supplied list of options (n = 96, multiple responses permitted)*

Training Area	n	%
Te reo Māori me ōna tikanga (Māori language and customs)	78	81
Governance	67	70
Management	54	56
Life coaching and mentoring	47	49
Te Tiriti o Waitangi (Treaty of Waitangi) training	43	45
Financial skills	40	42
The health system	38	40
Colonisation	32	33

**Percentages sum to more than 100 because respondents could select more than one option.*

Māori doctors also called for formal recognition of cultural responsibilities within employment agreements, including dedicated time and remuneration. One participant noted that although equity roles were promoted within job descriptions, “It took me time to realise there's no [time] allocation for any of that” (Focus group, Fellow). Some suggested that organisations should instead engage professional cultural advisors rather than relying on unpaid labour from Māori staff. At a broader level, participants emphasised the importance of training non-Māori colleagues in allyship and cultural competence so that responsibility for cultural work was more equitably shared across the workforce rather than falling primarily on Māori practitioners.

Community Cultural Load

A fundamental distinction

The responsibilities that came with community-derived cultural load were experienced differently from professional cultural load, in fact, participants were reluctant to describe it as a ‘load’, rather it was framed by some as a ‘contribution’ and we have chosen to label this aspect of cultural load, *community responsibilities*. Although these roles and responsibilities required significant time and energy, they were generally understood as obligations based on a sense of connection and collectiveness rather than any notion of exploitation. As one participant explained, “That's not the cultural load that we're worrying about... that's the stuff we do for love” (Focus group, Fellow).

Community responsibilities and contributions

Although the doctors we interviewed saw some demand of their time from family or community members as inevitable, it was viewed as an opportunity to contribute rather than an imposition. These requests were most often thought to be impossible to refuse, reflecting a shared sense of responsibility, “Being part of Māori hapori [community], they have these expectations of you, you know: You are us. You represent us. You need to fight this battle. You need to fix things” (Focus group, Fellow). Doctors emphasised that they were contributing their professional expertise in the same way others contributed practical or cultural skills within their communities.

Clinical advice and advocacy

Providing informal clinical advice and system navigation for whānau was described as routine rather than burdensome, “...and I'm getting text messages on ‘what's this new medicine the doc's trying to put me on?’” (Focus group, Fellow). There was a shared sense that there are systemic gaps in capability regarding Māori health and requests for help frequently arose from distrust of health services or concerns about unfair treatment. One participant said, “This is especially important for whānau with a terminal illness, our system does a shit job of looking after our whānau in this position. It is really important work” (Focus group, Fellow). This advocacy was viewed by participants and the community as necessary to ensure safe care. Some participants said that occasionally such interventions were lifesaving, reflecting those perceived gaps in the health system’s ability to provide equitable care. “We just do this because we have no other

choice. A number of my whānau would have died, had I not intervened on their behalf” (Focus group, Fellow).

Workload and impact, and reward

Survey data confirmed that community responsibilities required substantially less time than professional cultural load (Table 4). Nearly two thirds of respondents (64%) estimated their community commitment at four hours per month or less, compared with only a third reporting the same for professional cultural load (Table 2).

From the interview data we could see that these responsibilities increased with career stage, with senior doctors carrying additional leadership and community obligations, while younger doctors had not yet been given these roles. Despite the time demands, three quarters of survey respondents (75%) reported being pleased to take on community responsibilities (Table 4), describing them as among the most meaningful parts of their lives. Compensation was rarely expected, and contribution itself was viewed as the reward, “... you know, in many ways it’s a high point of my week” (Focus group, Fellow).

Table 4
Time, impact and experience of community responsibilities, survey respondents (n = 96)

Item	n	%
Hours per month on whānau/hapū/lwi/community roles*		
0–4 hours	61	64
5–8 hours	18	19
9–12 hours	6	6
13–15 hours	2	2
More than 15 hours	8	8
Impact on self and whānau		
No impact	19	20
Minor impact	49	51
Moderate impact	18	19
Heavy impact	10	10
Experience of community responsibilities		
Pleased to take on community responsibilities	72	75

***One respondent did not answer the hours item (n = 95)**

Community leadership and resilience

Māori doctors are often requested to take on whānau, hapū, Iwi and community leadership and other governance roles - marae committee member, trustee, treasurer, chairperson or as an expert witness in a Waitangi Tribunal claim. One participant said, “I recall going on the school board and I was trying to discuss all the challenges in looking at equity for Māori students. So you're in the education system and that's different to health, but you're still looking at equity and dealing with a lot of the same issues” (Focus group, Fellow). These roles provided cultural grounding and renewal that contrasted sharply with workplace experiences. Engagement with whānau, whenua (land) and whakapapa (family connections) was described as sustaining resilience in demanding professional environments. Another added, “I find it incredibly renewing and rejuvenating because I'm with my cousins and we're thinking broadly about radically changing the future for our people” (Focus group, Fellow). During events such as the COVID-19 pandemic, many doctors naturally assumed leadership roles in their communities, reinforcing both responsibility and collective commitment.

Meaningful acknowledgement from communities

It was noted that recognition received within communities felt more genuine than that experienced within workplaces. “It can be hard and stressful at the time, but afterwards usually comes a time of enormous gratitude for being the person that the community is comfortable reaching out to” (Survey respondent, Registrar). Expressions of gratitude and trust from whānau and communities contrasted with the lack of institutional acknowledgement often associated with professional cultural load. A final note, “I am asked by my whānau to do duties that require high trust” (Focus group, Fellow).”

Discussion

This research examined cultural load among Māori doctors in Aotearoa New Zealand. It describes the burden these doctors carry within their health institutions, identifies the institutional function that each form of that labour performs, and notes potential consequences for the Māori medical workforce. In addition, it documents the moral injury experienced by Māori doctors who felt complicit in perpetuating health systems that produce inequitable health outcomes for Māori. The research also describes, based on our a-priori assumptions, the fundamental difference(s) between workplace cultural load and the responsibilities Māori doctors hold within their communities. This dichotomy has not been previously described in the peer-reviewed literature.

The international literature describes the extra workload for Indigenous and non-white professionals with terms such as cultural taxation [1], minority tax [2], and colonial load [13]. These terms illustrate how such professionals are assigned responsibility for addressing the institutional shortcomings around Indigenous and non-white patients. Related literature links this burden to burnout and marginalisation of Indigenous health workers [12, 33, 34]. We adopted the term *colonial tax* as a name for this workplace load among Māori doctors. Similar to the Australian term, colonial load [13], it locates the origin of the additional labour in colonisation and repositions responsibility from the Māori doctor to the institutions and the health

system that New Zealand's colonial legacy has shaped. The colonial tax operates at both individual and systemic levels: it is levied on the individual doctor; it is paid for in unrecognised labour; it is collected across health institutions, who along with colleagues and patients, are kept afloat by it.

Our research also showed that cultural load can adversely reshape career trajectories, as the international literature also indicates [6, 7, 8]. An implication we had not anticipated is that cultural load threatens the retention of Māori doctors in the workforce. Expectations are placed on Māori doctors early, often before clinical confidence and networks are established, diverting time from clinical development and progression. We have linked cultural load to stress, exhaustion, burnout and job dissatisfaction, and ultimately to the reconsideration of medical careers. These are precursors to attrition and they threaten, as they have done with Māori teachers and scientists [14, 15], both retention and sustainable growth of the Māori doctor workforce. The international literature documents such attrition reducing the availability of culturally safe care and compounding inequitable health outcomes for Indigenous populations [8, 34, 36].

Alongside this workplace load, we also have described a second contrasting form, that is, the role Māori doctors hold within their communities, secondary to their professional status. They are frequently called upon to provide both medical and non-medical support to whānau and hapū (family and wider kinship groups), embodying the relational approaches recommended as appropriate for whānau Māori [37, 42, 43]. Unlike the workplace load, these roles were generally experienced by participants as meaningful obligations grounded in identity and belonging, rather than imposed burdens. They described these community responsibilities as privileges even when emotionally demanding. Similar patterns appear among Aboriginal community workers in Australia [13], Sámi health workers in Norway [36], and Māori nurses [35]. Strong cultural identity increases responsibility and the time devoted to fulfilling these roles [15, 36].

While interview participants reported cultural load at work as stressful, they found that resilience was derived from these cultural roles within their own communities. This distinction was borne out in the survey data: most survey respondents reported being pleased to take on community responsibilities; fewer hours were required for these responsibilities; and the personal impact was reported as lower. Because these roles were not perceived as exploitative, however, the personal impact may in fact be underestimated. Nevertheless, these roles provide connection, purpose, and the cultural grounding that counterbalance stressful professional environments and, in this light, the suggestion of 'contribution' rather than 'load' is a better framing. Distinguishing institutional load from community responsibility is important because community engagement appears to sustain the resilience that enables Māori doctors to stay in such demanding roles. This reframing matters because identity and connection are central protective factors for the wellbeing of Māori professionals [15].

We have grouped cultural load in the workplace into four categories, but they are more than a description of extra tasks because each performs a systemic function that would otherwise not be covered. These functions have wide implications because this labour fills health system gaps, conceals who is carrying the cost, relieves the pressure for change, and substitutes the appearance of change for change itself. Patient advocacy at work and in the community compensates for systemic failures in provision of culturally safe

care but health inequity persists; Māori committee participation does not necessarily change committee processes, clinician behaviour or clinical outcomes; provision of cultural infrastructure allows for some custom and ceremony without organisational commitment to a meaningful change in cultural practice; and Māori doctors teaching cultural safety means that health institutions do not have to expend resources to meet MCNZ standards and Waitangi Tribunal recommendations. Despite being experienced as contribution, community responsibilities fill system gaps in the same way with whānau advocacy and system navigation compensating for care the health system does not reliably provide. Perversely, the doctors most committed to Māori health equity are the same people whose uncompensated work in the health system and in the community props up the very system that produces inequitable outcomes for Māori patients.

Our participants had clear insight into this irony and their articulation of complicity connects our findings to the international moral injury literature. Clinician accounts of moral injury typically centre on being unable to provide the care the doctor believes is needed [44, 45]. Māori nurses reported a similar *emotional labour* accruing from routinely witnessing whānau not being given the care that they should receive [46]. Our participants name a further injury: knowing that their continued participation sustains the harm. In naming this workplace load as the *colonial tax*, we also note that moral injury of this kind is colonial in origin [13] and will not be healed by individual resilience [44]. Its remedy lies in system-level reform.

If the remedy is structural, the question becomes what structural change looks like. In the literature, interventions to mitigate the adverse effects of cultural load include: recognition of cultural work through formal job descriptions, allocated time for cultural roles, appropriate professional development support, and compensation rather than assumption of voluntary labour [15, 37]. Some organisations have trialled Indigenous cultural brokerage roles to do this work while others are training non-Indigenous staff to manage equity, cultural safety and diversity-related tasks [38, 34]. Such restorative and cultural safety approaches, which dismantle inequitable structures and support Indigenous staff networks, have followed formal accountability and reconciliation frameworks [14, 39].

Our own survey respondents recommended interventions at individual, organisational, workforce and wider health ecosystem levels, as well as the support of doctors in their community roles [29]. At an individual level, targeted support programmes for Māori doctors were recommended, with a priority around personal *reo* and *tikanga* capabilities alongside governance and management skills. Interview participants also described ‘learning to limit additional cultural work’ and while some literature describes declining or strategically leveraging these roles [8, 14], we found that many still felt obliged to accept it. Our findings echo concerns that a fixation on individual coping strategies cannot resolve structural inequities, and reliance on them risks undermining decades of strategic work to increase the numbers of Māori doctors [40, 41].

Addressing cultural load requires organisational transformation [7, 34]. We have therefore produced seven system-level recommendations that target institutional and structural change and indicated those responsible for implementation (Table 5). These include employers formalising cultural roles in job descriptions or hiring external contractors; resourcing allyship and cultural safety training; vocational

colleges managing cultural load in their training of doctors; and the wider health sector supporting personal development of Māori doctors to foster both patient care and the maintenance of the Māori medical workforce. Naming this workplace load as colonial tax locates both its origin and its remedy. Because these recommendations shift structural power and resources in favour of the Māori medical workforce, they are anti-colonial in intent and decolonising in effect [39, 47, 48].

Table 5
Recommended system-level actions and the actors responsible for implementation

Recommendation	Responsible actors
Formalise cultural duties in job descriptions with allocated FTE, financial recognition, and professional development support	Employers, health unions
Engage external cultural advisors and trainers rather than relying on unpaid Māori staff labour	Employers, Council of Medical Colleges (CMC) and all medical colleges
Resource allyship and cultural safety training for non-Māori clinicians so that cultural safety education does not default to Māori doctors	Medical Council of New Zealand (MCNZ), CMC and all medical colleges, employers
Establish mechanisms across the medical colleges to manage and distribute requests for Māori input across the workforce	MCNZ, CMC and all medical colleges
Require medical colleges to report annually to MCNZ on how they support Māori doctors to manage cultural load	MCNZ
Protect dedicated time and funding for Māori doctors to develop both their reo Māori and tikanga grounding, as well as formal governance skills	Employers, CMC and all medical colleges, Te ORA
Grow the Māori medical workforce so cultural responsibilities are shared across a larger group	MCNZ, medical schools, employers

The main strength of this study was that the mixed methods design combining focus groups across five specialties and wider survey responses from a substantial Te ORA membership was able to examine Māori doctors’ experiences of cultural load in detail. This study does, however have some limitations. Firstly, the voices of the smaller vocational colleges and their specialties were not represented. Similarities in findings across specialties in the qualitative data demonstrated internal consistency and while this is unlikely to have been an artefact of any single specialty context, it remains that the experience of smaller colleges’ members may well be different. Whilst Te ORA is the most accessible sampling frame for Māori doctors, its membership, which Te ORA records put at approximately 300, represents under a third of the 1020 Māori doctors registered with the MCNZ in 2024 [21]. Alongside that, MCNZ data in 2026 indicate that over half of the registered Māori doctor workforce hold RMO or registrar training positions [22], whereas registrars and RMOs made up only 28% of our survey respondents (Table 1b). The findings may therefore under-capture some experience, particularly that of early career Māori doctors.

The survey response rate was also modest. Although the 32% survey response rate means findings may not represent all Te ORA members, or indeed all Māori doctors, this rate does align with contemporary survey trends [49]. Finally, it remains that doctors carrying more substantial cultural load may have been more motivated to respond to a survey on the topic. Self-selection of this kind would inflate prevalence estimates and survey figures describe only our respondents and are best read as indicative rather than population estimates.

Conclusion

This study contributes new understanding of the cultural load Māori doctors carry in Aotearoa New Zealand. We adopt a participant's naming of the workplace or professional form of cultural load as the *colonial tax*. We also describe a significant community-derived load, one which we had conceived a-priori, that was made up of roles that arose within doctors' extended families, tribal and community networks. We have labelled these community responsibilities. The professional load compensates for systemic failures and, perversely, sustains the same system whose shortcomings it conceals. Participants' recognition of this complicity connects cultural load to moral injury, a dimension not previously documented in the peer-reviewed literature. Community responsibility, by contrast, is experienced as contribution rather than burden, and, although it too compensates for systemic failings, it nurtures the cultural grounding that keeps these doctors in demanding roles. Interventions must therefore lighten institutional load and, at the same time, support the community connection that sustains resilience. Unless institutional cultural responsibilities are equitably shared across the workforce or formally recognised in job descriptions with appropriate support, the burden on Māori doctors risks compounding inequities in care for Māori and accelerating workforce attrition. We therefore set out seven system-level actions, each with the actors responsible for delivering it (Table 5). Because these changes shift structural power and resources towards the Māori medical workforce, addressing the colonial tax is not only a workforce measure but a decolonising one.

Declarations

Ethical approval, consent to participate

This research was conducted in accordance with the National Ethical Standards for Health and Disability Research and Quality Improvement issued by New Zealand's National Ethics Advisory Committee, and with Te Ara Tika: Guidelines for Māori Research Ethics [50, 51]. Ethics approval was granted by the Eastern Institute of Technology Research Ethics Approval Committee (REF: EA18021122, 28 November 2022), which applies the Matarau Whānui Māori ethics assessment framework, based on the Te Ara Tika principles of whakapapa, mana, tika and manaakitanga. All participants received an information sheet and list of questions prior to participation and provided written informed consent for participation in the study.

Consent for publication

The written consent for participation included consent for publication of their anonymised responses.

Availability of data and materials

The datasets generated and analysed during this study are not publicly available because participant confidentiality cannot be assured within a small workforce. Data are held by Allen + Clarke under contract to Te ORA and are subject to Māori data sovereignty considerations.

Competing interests

DTL led the project, facilitated the interviews, selected the initial participant in each specialty group and, along with TR, is a senior figure in Te ORA which received the funding for this research and subcontracted the research team. DTL, SS, HH, VM and MC are co-authors of the Te ORA cultural safety work programme with the Medical Council of New Zealand and the Council of Medical Colleges that is cited in this paper. The authors declare no other competing interests.

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Authors' contributions

DTL led the overall project, facilitated the interviews, completed the review of the literature on cultural load, and drafted the manuscript for this paper. SS and MC participated in the design of the project, the running of the interviews and facilitated the analysis. HH, VM and TR contributed to design of the project, the organisation of the interviews, the review of the findings and approved the draft of this paper. TR also provided background health, quality and safety expertise and Te ORA contract work that led to this manuscript. All authors read and approved this final manuscript.

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Footnotes

1. Aotearoa New Zealand is used throughout this paper when referring to New Zealand as a shared space in which Māori hold interests, and New Zealand is used when referring to state institutions and systems.
2. *The Crown* in New Zealand refers to the enduring legal state whose executive authority is exercised by the government of the day.
3. Te Tiriti o Waitangi (the Treaty of Waitangi) is the 1840 agreement between Māori and the Crown, and the document on which the Crown bases its claim to sovereignty in New Zealand
4. *The Waitangi Tribunal* is a standing commission of inquiry established under the Treaty of Waitangi Act 1975 that investigates breaches of Te Tiriti o Waitangi.

Supplementary Files

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