

# 2<sup>nd</sup> Place Winner of 2025 Te Tupu Whakaritorito (PIF New Zealand) Competition

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## Essay topic – ‘Seeing the whole person beyond the diagnosis’

***He kokonga whare e kitea, he kokonga ngākau e kore e kitea***

The corners of the house may be seen, but not so the corners of the heart

### By William Guy

This whakataukī diagnoses a disease of modern medicine: our inability to see the whole person.

The dominance of the biomedical model has narrowed our clinical gaze to *the visible corners of the house*: the objective markers of disease. We diagnose and treat faster than ever, at the expense of exploring *the corners of the heart*: the subjective experience of illness. Without understanding the context and lived experience of illness the whole person disappears behind the diagnosis.

Our adherence to the biomedical model, which is driven by medical advancements and system-level pressures that reward clinical efficiency, actively perpetuates health inequities faced by Māori and other marginalised groups in Aotearoa. To address these disparities, the adoption of Indigenous health models at clinical and system levels is essential. These models provide a framework to see the whole person and to achieve health equity in Aotearoa. Psychiatry, an outlier in the biomedical paradigm, is uniquely positioned to champion this transformation.

### Our Narrowing Gaze

Since the 18th century, rapid scientific progress has resulted in diagnostic tools of unprecedented precision. While beneficial, they have reduced the lived experience of disease to objective measures: blood tests, scans, and biopsies. We now search for measurable pathology, with personal narrative being a secondary concern (Clarke et al., 2003). This reductionist approach is the cornerstone of the biomedical model, and it is further entrenched by system-level pressures—financial constraints, time limitations, and protocol-driven care. Paradoxically, as our ability to see disease has increased, our ability to see the whole person has decreased.

Psychiatry holds a contested position within this biomedical paradigm, reflected in the divide between the Kraepelinian drive to explain and classify disease biologically and the phenomenological legacy of psychiatrists like Karl Jaspers, who focused on the subjective experience of illness (Ghaemi, 2009a). This division has left psychiatry vulnerable to criticism from other specialties, and it is from this tension that George Engel first proposed the biopsychosocial model in the 1970s. He suggested illness, including non-psychiatric illness, arose from the interplay of biological, psychological, and social factors (Engel, 1977). By doing so, Engel provided an early attempt at broadening medicine’s gaze beyond biology.

### Impacts on Equity

Despite proving popular conceptually, the biopsychosocial model failed to displace the biomedical model as the dominant force in practice (Ghaemi, 2009b). The biomedical

model, with its homogeneous lens, continues to drive our research, health funding, and clinical decision making. This has created an evidence base and clinical guidelines that ignore cultural, social, or contextual differences, leading to a system that doesn't see the whole person.

The burden of this falls disproportionately on Māori and other marginalised groups. The Waitangi Tribunal concluded that our health system has failed to uphold Te Tiriti o Waitangi (Waitangi Tribunal, 2019; Came et al., 2020), resulting in inequitable outcomes for Māori. This failure stems from the exclusion of Māori worldviews, values, and definitions of wellbeing. In practice, this exclusion is reflected in Māori being twice as likely to be placed on compulsory community treatment orders and spending 44% longer on them than non-Māori counterparts—disparities not explained by diagnostic trends alone (Beaglehole et al., 2024).

However, the biopsychosocial model is no panacea. Even when it is utilised—as in contemporary psychiatry—it often fails to account for broader contextual factors such as cultural or spiritual beliefs or it collapses back into a biomedical formulation. Consider the clinical interpretation of auditory hallucinations. Within a biopsychosocial formulation, Western clinicians would label these a positive symptom of schizophrenia, whereas Māori may interpret them as expressions of matakite (prophecy) or spiritual communication with tūpuna (Taitimu, Read & McIntosh, 2018). The imposition of the diagnostic label of schizophrenia may feel culturally inconsistent with Māori belief systems, leading individuals to withhold their experiences for fear of being pathologised by clinicians. This is medical imperialism: the application of rigid Western diagnostic frameworks across diverse populations, invalidating Indigenous knowledge and experiences of illness (Summerfield, 2013). The Cultural Formulation Interview, designed to address this, remains an optional add-on, not a foundational shift in practice (Aggarwal et al., 2020), and lacks evidence for improving outcomes (Jarvis et al., 2020). When both our existing approaches fail to see the whole person, we must consider that the solution could lie outside of their shared Western paradigm. Achieving equity requires a shift in our thinking: not modifying or adding to pre-existing models, but adopting frameworks developed by the very knowledge systems they have excluded.

### **Indigenous Frameworks for Hauora**

The Meihana Model, developed by Māori mental health clinicians, provides a powerful alternative. Utilising mātauranga Māori and designed to validate Māori beliefs, values, and experiences, it addresses several limitations of the biopsychosocial and biomedical models.

The Meihana Model uses the metaphor of a waka hourua (double-hulled canoe), where the person and their whānau represent the two hulls (Pitama, Huria and Lacey, 2014). The voyage of the waka is shaped by surrounding conditions. The Meihana Model represents this through ngā roma moana, the ocean currents, of āhua, tikanga, whakapapa, and whenua. These currents signify the protective cultural factors that can support and enable Māori on their journey. The waka also faces ngā hau e whā, the four systemic winds of colonisation, marginalisation, migration, and racism. These currents and winds provide a more complete understanding of the individual's world than is possible with the biopsychosocial or biomedical model alone. The model transforms a clinical encounter into a holistic consultation that seeks to see and understand the whole

person. The model's core dimensions engage with universal human needs and concerns—such as identity, connection, belonging, and power structures. Although developed from a te ao Māori perspective, it offers a framework to guide holistic consultations with people from all backgrounds.

However, clinical-level change is not enough; we must design the health system to see and respond to the whole person. The Tū Kahikatea framework provides this lens by modelling health services as an interdependent ecosystem, akin to a Kahikatea grove (Reweti, 2023). The interwoven pakiaka reflect the collective strength and shared purpose of the individual and their whānau, forming the mauri that anchors the kaupapa. Ngā rākau (trees) embody the core values—such as manaakitanga, kotahitanga, and kaitiakitanga—which shape every policy, interaction and protocol. This design ensures services see the person within their whānau and community context. It is from this foundation that ngā hua (fruits) like whakamana (empowerment) and hauora emerge. Ngā manu (birds) can then disperse these positive outcomes, symbolising mana motuhake (self-determination) of service-users.

Together, the Meihana Model and Tū Kahikatea framework provide a foundation for seeing the whole person: one transforming the clinical encounter and the other reorienting our health system toward hauora and equity.

### **Integrating Holistic Models into Practice**

Consider a young Māori man presenting with agitation. A biomedical lens may frame this as 'acute psychosis,' whereas a biopsychosocial model might identify 'social stressors.' Applying the Meihana Model, you can look beyond these superficial interpretations. You see that his waka is unmoored. Strong ocean currents are making the waka drift: disconnection from whenua, grief for a deceased whānau member. Winds batter the waka: a noisy emergency department, distrust of a health system that has previously failed his whānau. His 'agitation' is not mental illness, but a reflection of a fragmented mauri—a waka struggling in a storm. Your role is not just to diagnose the damage to the hull, but to guide the waka to safe harbour.

A holistic clinical approach cannot be sustained by clinicians alone, we must have a health system that enables it. This is where a framework like Tū Kahikatea builds the harbour itself. Embedding such frameworks places whānau and values at the heart of service design, ensuring the service sees the whole person. Here, the roots of a service could be anchored in values like kaitiakitanga and manaakitanga. These roots nourish the work being done, in turn yielding the fruits of restored mauri, whakamana (empowerment), and rebuilt trust. These values make holistic care a requirement, not an option.

Together, these models compel us to see the whole person.

### **Conclusion**

Our narrowing gaze has redirected our focus from the corners of the heart to the corners of the house. This is no accident. It is a symptom of a system that prioritises metrics over narrative—and one that actively perpetuates inequity.

To refocus requires the adoption of Indigenous frameworks like the Meihana Model and Tū Kahikatea. These models do not just add cultural context to care; they fundamentally change how we see people and design services for them.

The call to action is clear. To honour Te Tiriti o Waitangi and to achieve health equity, we must move from advocacy to action: integrating Indigenous models into practice, championing their use, and redesigning our health services with whānau and shared values at their core.

Only then will we finally see, and care for, the person beyond the diagnosis.

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## **Appendix One – Glossary \***

Āhua – personal indicators of te ao Māori that are important to the patient/whānau

Hauora – health, vigour

Kaitiakitanga – guardianship, stewardship

Kaupapa – topic, policy, plan, purpose

Kotahitanga – unity, togetherness

Manaakitanga – hospitality, kindness

Mana motuhake – self-government, autonomy

Mauri – life force

Matakite – prophecy

Mātauranga – knowledge, wisdom

Ngā hau e whā – the four winds

Ngā hua – the fruits

Ngā manu – the birds

Ngā rākau – the trees

Ngā roma moana – the ocean currents

Ōritetanga – equality, equal opportunity

Pakiaka –root (of a tree)

Tikanga – Māori cultural principles

Tino rangatiratanga – self-determination, sovereignty

Toiora – well-being

Tūpuna – ancestors, grandparents

Waka hourua – double-hulled canoe

Whakamana – empower, validate

Whakapapa – genealogy, lineage

Whakataukī – proverb, aphorism

Whakawhanaungatanga – process of establishing relationships

Whānau –support network(s) for the patient, the relationships, roles and responsibilities of the patient within te ao Māori, including whānau, hapu, iwi and other organisations.

Whenua – specific genealogical or spiritual connection between patient and/or whānau and land

*\* Disclaimer: many of the descriptions used in this glossary are specific interpretations for this publication, and do not denote the fullness of meaning normally associated with the word or term. All efforts have been made to uphold the taonga of each kupu within the writing of this publication (Moorfield, 2011; Pitama, Huria and Lacey, 2014).*