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ORA

OPEN
REFLECT
ACTION

A relationship-centred framework for meaningful healthcare conversations

Supported by

TE TAURA WHIRI
I TE REO MĀORI
MĀORI LANGUAGE COMMISSION

ORA GUIDE AND WORKBOOK | A relationship-centred framework for meaningful healthcare conversations

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This guide and workbook has been developed to support reflective learning and professional development.
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How to use this guide

Part one: Introduction

Starts with a short summary of ORA, then explains the thinking behind it in more depth: why it was developed, who it's for, what shapes it, and how it was developed.

Part two: Te Ao Māori terminology

Supporting Kupu (words) and Te Ao Māori terminology as you work through this guide.

Part three: Scenario workbook

Presents five reflective scenarios exploring relationship-centred healthcare conversations, for individual reading or group discussion.

Part four: Facilitator guide

Provides facilitation guidance and discussion prompts for using the scenarios in Part Three with a group.

We recommend reading Part One first, before working through Part Three individually or as part of a facilitated session using Part Four.

An appendix on how ORA relates to other frameworks used in Aotearoa, including the Meihana Model and the Hui Process, and a glossary of te reo Māori terms used throughout this compendium, both appear near the end, before the evidence base.

PART ONE: Introduction

ORA is a relationship-centred framework for healthcare conversations, built around three elements: Open, Reflect, Action.

It isn't a script or a checklist. It's a way of noticing that a conversation can go well by every visible measure, and something might still be left unsaid.

OPEN

Relationship first

Create opportunities to build trust, connection, and genuine engagement.

REFLECT

Understand what matters

Explore different perspectives and build shared understanding.

ACTION

Plan together

Work alongside people to develop a shared plan.

These aren't sequential steps to complete and move past. They overlap, and often return to one another, sometimes across more than one conversation.

For example: a clinician might *open* space by asking how someone feels about going home, *reflect* by noticing a pause before they answer and gently checking what's on their mind, and from there begin planning *together*, even if that plan is provisional and returns at the next visit.

What to watch for

Quiet agreement doesn't always mean full understanding.

YOU NOTICE...	YOU COULD TRY...
A person becomes quieter or less engaged	"What's on your mind at the moment?"
Someone nods but doesn't ask questions	"Would it help to go through this together?"
A person appears overwhelmed	"There's a lot to take in. What feels most important right now?"
Whānau are present but quiet	"Would you like to talk through the plan together?"

The five scenarios in Part Three put this into practice.

The rest of this introduction explains the thinking, evidence, and development behind ORA in more depth. If you're ready to begin, the scenarios start in Part Three.

For how ORA relates to other frameworks used in Aotearoa, including the Meihana Model and the Hui Process, see the appendix.

Why ORA

Healthcare conversations often take place under real pressure. Limited time, competing priorities, busy environments, and people who may be meeting a clinician for the first time all shape what's possible in the room. Within these conditions, a conversation can be conducted well, with genuine respect and care on both sides, and understanding can still be incomplete.

This gap is well documented. The Institute of Medicine's landmark review of health system quality named patient-centredness as one of six essential dimensions of good care, alongside safety and effectiveness. This makes clear that clinical competence alone does not guarantee that a person feels heard or understood *(Institute of Medicine, 2001)*. Epstein and Street (2011) argue that patient-centred communication carries value in two ways at once: it is valuable in itself, as a form of respect for the person, and it is valuable instrumentally, contributing to better outcomes, trust, and adherence to care.

In Aotearoa, this gap has a documented cost for whānau Māori specifically. A 2022 Health Quality & Safety Commission report into whānau Māori experiences of major trauma care and rehabilitation found that when kaupapa Māori principles (wairuatanga, whanaungatanga, and kotahitanga) were genuinely present in care, whānau felt more engaged in the recovery process and found rehabilitation easier to navigate. The report calls for whakawhanaungatanga to sit at the centre of care for Māori, not as an add-on to clinical treatment *(Health Quality & Safety Commission, 2022)*. This direction is consistent with Pae Ora (Healthy Futures), the government's strategy for a health system oriented around people and whānau rather than institutions *(Manatū Hauora – Ministry of Health, 2023)*.

ORA responds to this evidence directly. The term relationship-centred care was first proposed by the Pew-Fetzer Task Force *(Tresolini & Pew-Fetzer Task Force, 1994)* and developed further by Beach and Inui (2006). They argued that healthcare relationships carry value in their own right, not simply as a means of delivering treatment, but as something formative to how care is experienced and how healing occurs.

ORA applies that idea to the unfolding, sometimes incomplete nature of a real conversation. It offers a way of noticing when under-standing may still be forming, and a shared language for continuing to build it, within a single conversation or across several, as trust develops over time.

Who ORA is for

ORA is intended for anyone involved in healthcare conversations, including nurses, doctors, allied health professionals, students, and educators, across a range of settings, from a busy ward round to a scheduled outpatient appointment.

It can be used individually, as a personal reflective practice tool, or with a team as part of professional development and facilitated discussion. It is not specific to one clinical specialty; while the Scenario Workbook draws on cardiac and respiratory examples, the underlying framework is intended to support relationship-centred conversations more broadly.

What ORA is, and isn't

ORA is a reflective learning resource, meant to be read, discussed, and returned to, building the awareness and curiosity that shapes how conversations unfold. It complements frameworks developed specifically to guide culturally safe practice with Māori patients and whānau, such as the Meihana Model and the Hui Process, which offer depth and specificity in their own areas of focus. See how ORA relates to these frameworks in the appendix.

What shapes ORA?

ORA has been shaped by relationship-centred practice, Te Ao Māori perspectives, reflective practice, and the lived experiences of people, whānau, clinicians, educators, and communities.

The name ORA reflects the framework's focus on health, wellbeing, relationships, and partnership. In te reo Māori, *ora* means health, wellbeing, and life itself, and it also stands for **O**pen, **R**eflect, **A**ction, the three elements at the centre of this framework. This dual meaning is deliberate: it acknowledges the Te Ao Māori perspectives that have influenced the development of ORA and its approach to healthcare conversations.

Whanaungatanga | Relationships
People do not enter healthcare as isolated individuals. They bring their experiences, identities, whānau, strengths, responsibilities, and hopes. Recognising these relationships helps create a fuller understanding of what matters to the person and those involved in their care. This reflects what whānau-centred research in Aotearoa has consistently found: that engaging whānau, not only the individual, changes both the experience and the outcome of care.[14]

Ako | Shared learning
Learning is reciprocal. Nobody holds all the knowledge: clinical expertise, lived experience, and the knowledge developed through caring for and supporting someone over time all contribute to understanding.

Whakamana | Recognising the strengths and knowledge of others
Clinical expertise and lived experience are not competing forms of knowledge. Together they contribute to a richer understanding of the person, their circumstances, and the decisions that follow.

Reflective practice
Reflection creates opportunities to pause, consider different perspectives, and allow understanding to develop before decisions are made. This draws on Donald Schön's influential account of "reflection-in-action": the idea that skilled professionals often respond to uncertain, unique situations not by applying a fixed rule, but by noticing when something doesn't fit expectations and adjusting their thinking in the moment.[13]

Lived experience. ORA has been shaped not only by principle, but by practice. Some of the scenarios in the Scenario Workbook draw on the real experiences of people and whānau who have generously shared their stories to help shape this resource. The people closest to a healthcare conversation often notice things a clinician cannot see from the outside. This is consistent with experience-based design research, which has shown that treating lived experience as a design input, not only a feedback mechanism, leads to service improvements that patients themselves recognise as meaningful.[1] Grounding ORA in real experience, not only in theory, is part of what keeps it honest about how these conversations actually unfold.

These ideas are explored in more depth, and put into practice, throughout the Scenario Workbook and Facilitator Guide.

About the development of ORA

ORA grew out of a cultural safety and competency workshop held with the cardiology department at Wellington Hospital, facilitated by Dame Naida Glavish. Following that workshop, staff came forward describing the everyday difficulty of healthcare conversations, including staff who had trained overseas and were still building familiarity with communication norms and cultural context in Aotearoa New Zealand. This mirrors what New Zealand nursing research has found more broadly: internationally qualified nurses often face real challenges navigating unfamiliar communication norms and workplace hierarchies, which can affect both team communication and patient care,[3] and their cultural and clinical transition into local practice takes genuine, ongoing support rather than a single orientation.[4] That feedback shaped the decision to develop a resource focused specifically on the relational side of these conversations.

Together, clinical expertise, cultural leadership, and lived experience, described further above, have shaped ORA into the resource it is today.

Looking beneath the conversation

Healthcare conversations often reveal only part of what someone is experiencing. Questions, concerns, strengths, previous experiences, and sources of support may not always be immediately visible. They often emerge as trust develops and conversations continue.

ORA encourages clinicians to remain open rather than making early assumptions about what may be influencing a conversation. This mirrors guidance from Te Tāhū Hauora on communicating effectively with older people and their whānau, which similarly cautions against reading quiet agreement as full understanding, particularly where a person may feel reluctant to ask questions or take up more of a clinician's time.[15]

YOU NOTICE...	YOU COULD TRY...
A person becomes quieter or less engaged	"What's on your mind at the moment?"
Someone nods but doesn't ask questions	"Would it help to go through this together?"
A person appears overwhelmed	"There's a lot to take in. What feels most important right now?"
Someone seems uncertain about going home	"How are you feeling about going home?"
Whānau are present but quiet	"Would you like to talk through the plan together?"
A person says they will manage everything alone	"What support do you have around you at the moment?"
A person appears worried or hesitant	"What concerns do you have at the moment?"

Rather than rushing to explain or solve every situation, ORA encourages clinicians to remain open, avoid assumptions, and recognise that understanding often develops over time.

PART TWO:
Te Ao Māori terminology

The three pages that follow – **Caring for a Māori patient and whānau** (page 7) and **Māori health – hospital care** (pages 8-9) were prepared by Sir John Clarke, the Foundation's cultural advisor, following the 2025 workshop with the Wellington Cardiology team that also shaped ORA.

They sit alongside ORA as practical, quick-reference guidance for caring with Māori patients and whānau, rather than as a relationship-centred framework in their own right. Where ORA offers a way of noticing and responding within a conversation, these pages offer specific practical guidance to turn to before or during care.

You'll notice some repetition between the two: page 7 speaks generally to caring for a patient and whānau, while pages 8-9 focus specifically on hospital care. Where they overlap, take that as reinforcement of what matters most.

Read them together: let the relationship lead, and use these pages for the practical detail underneath it.

Caring for a Māori patient and whānau

1. Holistic view of health (Te Whare Tapa Whā)

Māori health is seen as the balance of four interconnected dimensions:

- Physical wellbeing
- Mental and emotional wellbeing
- Spiritual wellbeing
- Family and social wellbeing

Practical tip: Care plans should recognise all four dimensions – not just physical illness.

2. Whānau involvement

- Whānau (family) are central to Māori wellbeing and decision-making.
- Illness affects the whole whānau, not only the individual.
- **Kaumatua** (elders) may provide spiritual or cultural leadership.

Practical tip: involve whānau in care discussions, provide space for them, and allow time for collective decision making.

3. Wairua (spiritual care)

- Spiritual health is vital to healing.
- Illness may be linked to spiritual causes (**mate Māori**).
- **Karakia** (prayer) may be said before or after treatment.
- **Taonga** (treasured objects) such as **pounamu** or photos may provide comfort.

Practical tip: support requests for **karakia** and handled **taonga** with care and permission.

4. Tapu and Noa

- **Tapu** = sacred or restricted
- **Noa** = ordinary or free from restrictions
- Specific actions (e.g. placing food near equipment or touching the head) can breach tapu

Practical tip: Keep food separate from clinical or bodily items and allow patients/whānau to perform cleansing rituals (e.g. hand washing or karakia).

5. Death and dying (Mate Tangihanga)

- Dying is seen as a spiritual transition, not an end.
- Whānau may wish to stay with the **tūpāpaku** (body) until burial.
- **Tangihanga** (funeral rituals) are sacred and may involve large gatherings.
- The body is highly **tapu**, avoid unnecessary handling without consultation.

Practical tip: Allow time and privacy for mourning, karakia, and cleansing rituals. Do not serve food near the body or equipment used for the deceased.

6. Communication and respect

Begin with **whakawhanaungatanga**

- Take time to build rapport and personal connection.
- Correct pronunciation of names and respectful tone matter.
- Explain procedures clearly and check for understanding.

Practical tip: Acknowledge identity and iwi if shared. Empathy and warmth build trust.

CULTURAL ASPECT	APPROACH
Whānau involvement	Include family in all decisions
Spiritual wellbeing	Allow karakia, respect taonga
Tapu and noa	Keep food separate, allow cleansing
End-of-life care	Support whānau presence and rituals
Communication	Build trust and connection
Holistic care	Addresses body, mind, spirit and whānau

He kupu whakamutunga – final note:

Respecting Māori beliefs and values, strengthens healing, builds trust, and upholds the principles of **Te Tiriti o Waitangi – partnership, protection, and participation.**

Māori health – hospital care

The topic of Māori Health is discussed in conjunction with the concept of Te Whare Tapa Whā.

Te Whare Tapa Whā is a wellbeing model developed by one of New Zealand's foremost health advocates, Sir Mason Durie, conceived in 1984, first published in Durie (1985). It describes health and wellbeing as a wharenui, or the main house on a marae.

The four sides or taha of the wharenui represent the four dimensions of one's holistic wellbeing. Taha Wairua/spiritual wellbeing, Taha Hinengaro/mental and emotional wellbeing and Taha Whānau/ Family and Social and Taha Tinana/ Physical wellbeing.

1. Holistic view of health

Māori see health as a balance of **wairua** (spirit), **hinengaro** (mind), **tinana** (body), and **whānau** (family). This holistic model is captured in **Sir Mason Durie's Te Whare Tapa Whā**, which compares wellbeing to the four walls of a house – all are needed for stability.

- **Taha wairua (spiritual health):** Connection to ancestors, faith, and the spiritual world. Disruption of wairua can cause illness.
- **Taha hinengaro (mental, emotional health):** Emotional wellbeing, expression, and dignity.
- **Taha tinana (physical health):** The body and its care.
- **Taha whānau (family health):** The importance of family support and collective identity.

Practical approach: Allow time and space for spiritual or family practices, respect karakia (prayers), and engage the whānau as part of the care team.

2. Whānau involvement

Whānau play a central role in Māori health decisions. It's not just about the individual.

- Illness affects the collective.
- Whānau may wish to be present at consultations, decision-making or during treatment.
- They may bring **kaumātua** (elders) to provide guidance or perform **karakia**.

Practical approach: Involve whānau early, provide adequate space for them, and respect collective discussion before making decisions.

3. Wairua (Spirituality)

The spiritual dimension is deeply respected. Many Māori believe that illness can result from a breach of tapu (a sacred law) or **disturbance of wairua**.

- **Karakia (prayer)** is often said before and after procedures, and before meals.
- Some may request to have **taonga (sacred objects)** such as pounamu or photos near them for spiritual comfort.
- Certain areas of the body, such as the head, are tapu (sacred) – avoid touching the head or passing objects over it without permission.

Practical approach: Ask before moving taonga, support karakia, and recognise the significance of wairua to spiritual matters.

4. Attitude to illness and death (Mate and Mate Māori)

'Mate Māori' refers to illness with spiritual or cultural causes – sometimes linked to **tapu violations, ancestral displeasure, or unresolved matters**.

- Serious illness or impending death is treated with **dignity, calmness, and collective suppor**t.
- Death (mate) is viewed as a **natural part of life's cycle**, with deep spiritual and ancestral connections.
- **Tangihanga (funeral rites)** are central, often involving gatherings at the marae, speeches, songs, and rituals to guide the wairua to the afterlife in the hospital room afterwards.

- The **body is tapu**, and special care is taken not to mix food and body items.
- **Whānau may wish to stay with the deceased** until burial and may perform cleansing rituals in the hospital room afterwards.

Practical approach:

- Allow whānau to stay with the dying or deceased person.
- Do not move nor handle the tūpāpaku (body) without family consultation.
- Offer a private space for mourning and karakia.
- Avoid serving food near the body or clinical equipment used for the deceased.

5. Tapu and Noa (Sacred and ordinary states)

- **Tapu** means sacred, restricted, or spiritually potent.
- **Noa** means ordinary, free from restrictions – achieved through rituals like washing hands or saying karakia.
- Hospital environments can easily disrupt this balance (e.g. mixing food and medical equipment, touching the head, or placing items on pillows).

Practical approach:

Respect tapu boundaries – keep food separate from clinical or bodily items, and allow handwashing or water rituals after touching the body.

6. Communication and respect

- Warm, respectful, and patient interactions matter.
- Proper **pronunciation of names and acknowledging iwi or whakapapa** (if offered) show cultural respect.
- Begin interactions with **whakawhanaungatanga – establishing personal connections before asking** medical questions.

Practical approach:

Take time to connect personally, explain procedures clearly, and acknowledge cultural values.

Summary

CULTURAL ASPECT	KEY CONSIDERATIONS IN HOSPITAL CARE
Whānau involvement	Include family in all key discussions and decisions
Spiritual needs (wairua)	Allow karakia, respect taonga, provide a quiet space
Tapu and noa	Keep food separate, respect the body/head, support cleansing
Death and dying	Allow rituals, whānau presence, and tangihanga traditions
Communication	Build rapport, use correct pronunciation, show empathy
Holistic approach	Address physical, spiritual, emotional, and family dimensions

PART THREE: Scenario workbook

This workbook has been developed to support reflective learning and professional development.

Most of the scenarios in this section are fictional composites, drawn from situations commonly encountered across healthcare settings.
Some scenarios draw on the real experiences of people and whānau who have generously shared their stories to help shape this resource. Identifying details have been changed throughout to protect privacy.

Using this workbook

This workbook has been designed to support individual reflection, group discussion, and professional learning.

Each scenario presents a fictional healthcare interaction based on situations commonly encountered across clinical practice.

As you work through each scenario, you will be invited to:

- reflect on your initial impressions
- consider additional information as it becomes available
- explore the interaction through an ORA lens
- identify insights that may inform your own practice.

There are no right or wrong answers.

The value of each scenario lies in the opportunity to consider different perspectives, explore complexity, and reflect on how healthcare relationships influence experiences of care.

You don't need to answer every question in one sitting. Reading a scenario and sitting with a couple of questions that stand out is just as valid as working through the whole set, and you're welcome to come back to a scenario later with fresh eyes.

You may choose to work through the scenarios independently, or alongside Part Four: Facilitator Guide, to support team learning, peer discussion, or professional development activities.

Scenario 1 | Cardiology Ward

It is mid-morning on a busy cardiology ward at a tertiary hospital. The ward is full, staffing is stretched, and several patients are waiting for review and discharge planning. Due to bed shortages elsewhere, some patients have been transferred from outside the region.

A consultant leads the ward round alongside a registrar, junior doctor, and nurse.

The team moves steadily between patients, stopping briefly at each bed.

Staff move in and out of rooms nearby, phones ring intermittently, and conversations continue quietly across the ward.

Wiremu, a Māori man in his 50s, was transferred to Wellington several days earlier following his first cardiac event.

He is medically improving and discussions about discharge have begun.

His sister, Mere, is sitting beside the bed when the team arrives.

The consultant greets Wiremu and briefly reviews his progress.

"How're you feeling today?"

"Yeah, better," Wiremu replies. "Bit tired still."

The consultant nods while looking through the notes.

"Your observations are looking good. If things continue like this, we'll likely look at discharge in the next day or two."

Wiremu nods quietly.

The consultant explains the medication plan and follow-up arrangements while the registrar takes notes.

Partway through the conversation, the consultant is briefly interrupted by a pager notification and glances toward another staff member waiting nearby.

"You'll need to keep taking these medications regularly once you're home. We'll organise follow-up and cardiac rehab information before discharge."

"Okay," Wiremu says.

Mere asks quietly, "Will any of that happen closer to home?"

"We'll try to coordinate as much as we can locally," the consultant replies. "The team will go through the details before discharge."

Mere nods.

The consultant continues discussing next steps and asks whether there are any questions.

Wiremu glances briefly toward Mere, then back toward the team. He shifts slightly in the bed as though about to speak, but after a moment simply nods.

"Nah, all good," he says.

"Okay," the consultant replies. "We'll check in again tomorrow."

The team moves on to the next patient.

Initial reflection

- What stood out to you in this interaction?
- What suggested comfort, understanding, or uncertainty?
- What role did the ward environment play?
- What assumptions could easily be made here?

Additional context

Later that afternoon, a nurse checks in with Wiremu and Mere.

"Is there anything you're still unsure about at the moment?"

Mere hesitates briefly.

"I think we understood most of it," she says quietly. "We just didn't really want to hold everyone up before."

The nurse asks if there is anything in particular they are worried about.

"I think we're still trying to work out how it's all going to work once we get home," Mere says.

Later that evening, Wiremu asks the nurse whether he will still be able to travel home by car once he is discharged.

After a short pause, he says quietly:

"I didn't really want to ask too many questions before. Everyone seemed pretty busy."

The nurse asks if there is anything in particular he is unsure about.

Wiremu shrugs slightly.

"I think I'm still trying to get my head around all of it really."

Deeper reflection

- Did your view of the interaction change as more context emerged?
- What may have made it difficult to raise questions during the ward round?
- What pressures were affecting everyone involved?
- What feels familiar about this interaction?

Through an ORA lens

This interaction was respectful and clinically appropriate in many ways. Both the clinical team and whānau appeared to be doing their best within a busy and pressured environment.

At the same time, some uncertainty remained unspoken.

Small relational shifts may help create more space for participation, including:

- allowing a little pause after questions
- inviting follow-up questions later
- checking what still feels unclear
- recognising that quiet agreement may not always reflect full understanding.

Examples might include:

- “There’s a lot to take in. What’s still on your mind?”
- “Sometimes people think of questions later too.”
- “What still feels a bit unclear at the moment?”

ORA reflection

OPEN | Relationship first

- What helped create a sense of respect or trust in this interaction?
- What may have made it harder to speak openly during the ward round?

REFLECT | Understand what matters

- What may not have been fully understood or discussed?
- What else may have been happening for Wiremu and Mere beneath the surface?

ACTION | Plan together

- What small shifts may have helped create more space for questions or shared planning?
- How might understanding continue to develop across multiple conversations?

Closing reflection

Relationship-centred care does not always require lengthy conversations or perfect solutions.

Often, small moments of openness, curiosity, clarification, or reassurance can shape how people experience healthcare interactions, particularly within busy and pressured environments.

Scenario 2 | General Practice

It has taken Hana nearly three weeks to get a GP appointment. The clinic has been short-staffed for some time, and she has seen several different doctors over the past year depending on availability.

Most appointments feel rushed, so she has learned to prioritise what she brings up.

Hana is in her mid-20s and has lived with asthma since childhood. Over the past few months, her breathing has gradually become worse. She has been waking at night more often, relying on her inhaler more frequently, and feeling increasingly tired during the day.

She considered booking an appointment earlier but kept putting it off. Work has been busy, appointments are hard to get, and part of her felt she should be managing it herself. By the time she arrives at the clinic, she already feels tense.

The GP briefly reviews Hana's notes before entering the room. The appointment is already running behind schedule.

"How can I help today?" the GP asks.

Hana hesitates briefly.

"My asthma's been playing up a bit."

The GP asks about symptoms, inhaler use, and whether Hana has had any recent illnesses.

Hana answers quietly and briefly at first. "Just been a bit wheezy lately."

The GP continues asking questions while making notes.

"How often are you using your reliever inhaler at the moment?"

"Probably a bit more than usual."

The GP nods.

"Have you been using your preventer regularly?"

"Mostly."

The conversation continues, focusing on symptoms and medication management. The GP explains that poorly controlled asthma can worsen over time and discusses adjusting Hana's medications.

Hana nods along.

Near the end of the appointment, the GP begins summarising the plan and mentions arranging another review in a few weeks.

There is a short pause.

Hana looks down briefly before speaking.

"I wasn't really sure if I should even come in."

The GP looks up from the notes.

"What made you feel that way?"

Hana shrugs slightly.

"I don't know. It's hard getting appointments. And usually when I come, it feels like there's only time to talk about one thing."

The room is quiet for a moment.

Then Hana adds softly: "I think I've just been trying to push through it for a while."

The GP pauses for a moment.

"It sounds like there's been quite a bit going on for a while," they say.

Hana nods quietly.

The GP glances briefly at the clock before turning back toward Hana.

"I know we probably can't work through everything properly today," they say, "but I do want to make sure we keep talking about it."

Together, they discuss adjusting Hana's asthma management plan and arranging a follow-up appointment to review her symptoms, medications, and any other concerns that have been building over time.

Initial reflection

- What stood out to you in this interaction?
- What suggested comfort, tension, or uncertainty?
- What assumptions could easily be made early in the consultation?
- What role did time, access, or continuity appear to play?

Follow-up appointment

Hana returns to the clinic two weeks later. This time, the conversation feels slightly easier to begin.

As they talk, Hana admits she has been using her reliever inhaler much more frequently than she first described during the previous appointment.

She also mentions waking during the night several times a week but says she "didn't want to sound dramatic before."

The GP asks whether there has been anything

making asthma management difficult recently.

Hana hesitates. "Sometimes I try to make the inhalers last longer." The GP asks what she means.

"They're expensive sometimes, and I kept thinking maybe things would settle down again."

Later in the appointment, Hana mentions she has also been feeling constantly tired but had decided not to bring it up during the earlier appointment because she thought there probably wouldn't be enough time.

Deeper reflection

- Did your understanding of the interaction change as more context emerged?
- What may have shaped Hana's decision to delay seeking care?
- What assumptions could easily form in short or fragmented consultations?
- What pressures or limitations were affecting both Hana and the GP?
- What aspects of this interaction feel familiar within healthcare settings?

Through an ORA lens

This consultation began with a focus on symptoms and treatment, but a different picture emerged as the conversation continued.

ORA invites reflection on how access, continuity, trust, and time can influence what is shared, delayed, minimised, or left unsaid within healthcare conversations.

ORA reflection

OPEN | Relationship first

- What helped create connection or openness during this interaction?
- What may have contributed to Hana arriving feeling tense or guarded?

REFLECT | Understand what matters

- What may not have been obvious early in the consultation?
- What wider pressures or experiences may have been influencing Hana?

ACTION | Plan together

- What small shifts may have helped create more space for honesty or shared planning?
- How might trust or understanding continue to develop across future appointments?

Closing reflection

The first concern raised is not always the concern that matters most.

Some stories take time to unfold.

Scenario 3 | Cardiology Outpatient Clinic

The cardiology outpatient clinic is running behind.

Before calling in the next patient, the heart failure nurse specialist reviews the notes.

Sione is a 58-year-old man who has attended the clinic since being diagnosed with heart failure 18 months ago.

Several concerns stand out.

Two follow-up appointments have been missed.

An echocardiogram remains outstanding.

Blood tests requested at his last review have not been completed.

Several attempts to contact him by phone have been documented.

The nurse specialist calls Sione into the consultation room.

"How have things been since we last saw you?"

"Not too bad."

Sione says his breathing has been alright, he still gets tired sometimes, and he has been taking his medication.

The nurse specialist then raises the outstanding appointments and investigations.

"I noticed there are a few things we haven't managed to complete yet."

Sione nods. "Yeah... been a bit busy."

Initial reflection

- What stood out to you in this interaction?
- What concerns might you have at this point?
- What assumptions could easily begin to form?
- What information feels missing?
- What might you want to explore further?

Additional context

The nurse specialist gently explores what has been happening.

Sione explains that his daughter usually takes him to appointments, but since changing jobs her hours have become unpredictable, making transport difficult.

Later, the nurse specialist asks about the outstanding blood tests.

"I can see we were waiting for some blood tests after your last review."

Sione looks surprised.

"I thought that was supposed to happen when I came back here."

He hadn't realised he needed to arrange them before his appointment.

As they continue talking, Sione admits he isn't always sure who to contact if he needs to change an appointment.

"I've seen the number on the letters," he says quietly. "I just didn't want to keep bothering people."

The nurse specialist notices several documented attempts to contact him.

"Were you getting the messages?"

"Sometimes."

Sione pauses. "I don't always answer numbers I don't know."

Then he adds, "Sometimes I think I'll ring back later... then I forget."

Rather than simply booking another appointment, they work through each step together, deciding where to have the blood tests, who to contact if plans change, and what to do if transport becomes a problem.

As they talk, Sione begins asking questions that suggest he has been trying to navigate the health system on his own for some time.

Near the end of the consultation, the nurse specialist asks, "How are you feeling about everything at the moment?"

Sione thinks for a moment. "It's a lot sometimes."

He smiles. "But I'm trying."

The nurse specialist smiles back.

"I can see that."

Deeper reflection

- How did your understanding of Sione change as the consultation unfolded?
- What assumptions could easily form from the documentation alone?
- What information became important that wasn't visible at the beginning?
- How might Sione's engagement have been interpreted differently by different clinicians?
- What role did the healthcare system play in shaping each person's understanding of the situation?

Through an ORA Lens

Before the conversation began, the documentation already suggested a story about Sione's engagement with care.

As the discussion unfolded, additional information changed how that story could be understood.

ORA invites reflection on how assumptions form, how understanding develops, and how healthcare systems can shape a person's ability to engage with care.

ORA reflection

OPEN | Relationship first

- What helped create space for the conversation to unfold?
- What assumptions may have influenced the interaction before it began?

REFLECT | Understand what matters

- What information became important as more context emerged?
- What factors may have been influencing Sione's decisions and actions?

ACTION | Plan together

- How might the nurse specialist and Sione work together moving forward?
- What small changes could support clearer understanding and follow-up?

Closing reflection

Documentation can provide important information, but it rarely tells the whole story.

Understanding often develops through conversation, curiosity, and a willingness to remain open to information that may not be visible at first.

Scenario 4 | Respiratory assessment

Kararaina is 67 years old and has lived with COPD for many years. She is the primary caregiver for her three mokopuna, aged 6, 9 and 11, who live with her full-time.

Over the past week she has become increasingly breathless. Everyday tasks are taking longer and requiring more effort than usual. She has found herself stopping more often to catch her breath while getting the children ready for school, preparing meals, and managing the day-to-day routines of the household.

After encouragement from whānau, she presents to hospital for assessment. The respiratory consultant reviews her assessment and investigations before meeting with her.

After discussing her symptoms and examination findings, the consultant leans forward slightly.

"I'm concerned about how you've been over the last week."

Kararaina nods.

"I think the safest option would be to admit you for a few days so we can monitor you closely and get on top of this."

Kararaina is quiet. She nods again but doesn't respond immediately. The consultant waits.

After a few moments, Kararaina says quietly:

"I don't know if I can do that."

Initial reflection

- What stands out to you at this point?
- What might be contributing to Kararaina's hesitation?
- What information would you want to understand before continuing the discussion?

Additional context

The consultant asks: "What are your thoughts about staying in hospital?"

Kararaina sighs. "I've got my mokopuna at home."

The consultant nods. "Tell me a bit about that."

Kararaina explains that her three mokopuna live with her full-time.

She gets them ready for school each morning, organises lunches, helps with homework, and manages the day-to-day routines of the household.

The consultant asks whether there is someone else who could step in.

Kararaina shrugs. "Not really. My daughter helps when she can, but she's working."

The conversation continues. The consultant begins to understand that Kararaina is not questioning the recommendation itself. She is trying to work out what happens to the children if she stays in hospital.

The consultant sits quietly for a moment.

"I can see why this is difficult."

Kararaina nods. "If it was just me, I'd stay. But it's not just me."

There is a brief silence.

The consultant asks: "Have you had a chance to talk with anyone about helping with the kids if you needed to stay in hospital?"

Kararaina shakes her head. "Not really. I only came in this morning."

Together they begin exploring what support might be available. Kararaina mentions her daughter may be able to help for a day or two, but she is unsure what arrangements could be made beyond that.

The consultant asks whether there are other whānau members who might be able to assist.

Kararaina shrugs. "Maybe. I'm not sure."

The conversation shifts away from whether Kararaina should be admitted and towards what would need to happen for admission to be possible.

The consultant explains why they are concerned about her breathing and why they believe inpatient treatment would be beneficial.

Kararaina listens carefully. "I understand."

The consultant nods. "I can see that."

Neither person appears to disagree with the other.
The challenge is not understanding.
The challenge is finding a way forward. Together they explore available supports, treatment options, and follow-up arrangements.

By the end of the discussion, a plan has begun to take shape. It may not be the ideal plan either person originally imagined, but it is a plan developed together.

The consultant explains that admission remains an option if Kararaina's symptoms worsen or if the plan becomes difficult to manage.

Before leaving, Kararaina says: "I'm glad we talked it through."

The consultant smiles. "So am I."

Neither person has achieved their ideal outcome. The consultant would have preferred admission. Kararaina would have preferred not to need additional care at all.

But together they have developed a plan that feels achievable and responsive to what matters most right now.

Deeper reflection

- When did the focus of the conversation begin to shift?
- What helped move the discussion from understanding the problem to exploring solutions?
- How did Kararaina's priorities influence the planning process?
- How might the conversation have unfolded if the consultant had focused only on the clinical recommendation?
- What role does flexibility play in relationship-centred care?

Through an ORA lens

Both Kararaina and the consultant recognised the seriousness of the situation, yet neither person's concerns were in conflict.

As the conversation unfolded, the challenge became not whether treatment was needed, but how it could work within the realities of Kararaina's life.

ORA invites reflection on how healthcare decisions are shaped not only by clinical needs, but also by the realities, responsibilities, and relationships that people carry beyond the healthcare setting.

ORA reflection

OPEN | Relationship first

- How did the consultant create space for Kararaina to express her concerns?
- What might have happened if the conversation had focused only on the admission recommendation?

REFLECT | Understand what matters

- What mattered most to Kararaina in this situation?
- How did understanding Kararaina's circumstances change the direction of the conversation?

ACTION | Plan together

- How did the conversation move from understanding to planning?
- What does shared decision-making look like when there are no easy solutions?

Closing reflection

Understanding what matters to a person does not always change the clinical situation.

It can, however, change what becomes possible when planning care together.

Scenario 5 | Shared expertise

Tama is 14 years old and has lived with severe asthma and bronchiectasis since early childhood.

Over the years he has experienced numerous hospital admissions, outpatient appointments, and periods of intensive treatment. His condition has had a significant impact on school, family life, and everyday routines.

Tama and his whānau are well known to the paediatric respiratory team. Together, they have spent years developing a shared management plan based on clinical expertise and the whānau's lived experience of caring for Tama.

The plan has evolved over time, bringing together clinical expertise and the knowledge gained through years of caring for Tama. It provides a shared approach to recognising deterioration, responding to exacerbations, and guiding his care during hospital admissions.

Despite this, Tama is admitted to hospital again following another acute exacerbation.

Once Tama's condition has been stabilised, the respiratory consultant arranges a meeting with Tama and his whānau.

"We've been working together for a long time," the consultant begins.

Everyone nods.

"I know we've all put a lot of thought into Tama's care over the years."

The consultant pauses.

"I'm interested in hearing how things have been working from your perspective."

Initial reflection

- What stands out to you at this point?
- What strengths are already evident within this relationship?
- What different forms of expertise are present?
- What do you think this conversation might focus on?

Additional context

There is a brief pause before Tama's grandmother speaks.

"Can I ask something?"

"Of course," the consultant replies.

"We've had a plan for years."

The consultant nods.

"We know the plan."

"So do you."

Another pause.

"But sometimes when Tama comes into hospital it feels like we have to start all over again."

The room falls quiet. Tama's mother continues.

"We find ourselves explaining the same things again."

"Sometimes we're offered treatments that haven't worked well for Tama before."

"It's like everyone has to catch up before we can get back to the plan we already know works."

The consultant listens carefully.

Tama speaks quietly.

"I end up telling different people the same story."

The consultant nods.

"So the challenge isn't developing a better plan."

"No," Tama's grandmother replies.

"It's making sure everyone knows it and trusts it."

The discussion shifts.

Rather than changing the management plan, they explore how it is communicated across the healthcare team.

They discuss how new clinicians become familiar with the plan, how key information is highlighted during future admissions, and how whānau knowledge can continue to inform decisions without needing to be re-established each time.

The consultant reflects that the plan represents years of shared learning between Tama, his whānau and the respiratory team.

The challenge is ensuring that shared learning travels with Tama wherever he receives care.

Deeper reflection

- How did your understanding of the conversation change as more context emerged?
- What challenges were being described beyond Tama's clinical condition?
- What role does continuity play in relationship-centred care?
- How can healthcare teams build on knowledge that already exists rather than repeatedly starting again?
- What systems help preserve shared understanding across different clinicians and settings?

Through an ORA lens

Years of partnership had already created a shared understanding of Tama's condition. The challenge was not developing new knowledge, but ensuring that existing knowledge remained visible, trusted, and consistently applied across different healthcare encounters.

ORA invites reflection on how relationship-centred care extends beyond individual conversations to include the systems, communication, and teamwork that help preserve shared understanding over time.

ORA reflection

OPEN | Relationship first

- How did the consultant create space for the whānau to raise concerns beyond the current admission?
- What helped this become a shared conversation rather than simply a clinical review?

REFLECT | Understand what matters

- What did the whānau's experience reveal about continuity of care?
- How did lived experience complement clinical expertise in this discussion?

ACTION | Plan together

- What practical steps could help ensure the agreed plan is consistently recognised and followed?
- How can healthcare teams preserve shared understanding when different clinicians become involved over time?

Closing reflection

Partnership is strengthened not only by creating shared plans, but by ensuring that shared knowledge is recognised, trusted, and carried forward across every healthcare encounter.

Continuing the conversation

You have now completed five scenarios exploring relationship-centred care across a range of healthcare settings.

Each scenario presented a different situation, but none was intended to provide a single “right” answer or a perfect example of practice.

Instead, they were designed to encourage reflection and discussion about the many factors that shape healthcare relationships.

Every healthcare conversation is different.

The people, circumstances, priorities, and decisions will continue to change.

ORA is not intended to provide a formula for those conversations.

Instead, it offers a framework to support reflection, strengthen relationships, and guide shared understanding in practice.

We encourage you to continue these conversations with colleagues, learners, and healthcare teams as you reflect on your own practice.

The workbook may be complete.

The next conversation is not.

Every conversation becomes part of the care that follows.

ORA reflection worksheet

Use this worksheet to reflect on healthcare conversations, relationship-building, and shared care planning in everyday practice.

OPEN – Building connection

How did you begin the conversation?

What helped create trust, openness, or connection?

What did you notice about engagement with the person or their whānau?

REFLECT – Understanding context

What seemed important to the person or whānau?

What strengths, supports, values or priorities emerged?

Were there any concerns, pressures, or barriers affecting the conversation or care planning?

What may have remained unspoken?

ACTION – Planning together

How were decisions or next steps discussed together?

Were whānau or support people involved where appropriate?

What helped support shared understanding or planning?

Looking back:

What felt effective in this interaction?

What felt challenging or uncertain?

What would you approach differently next time?

What did this interaction teach you about relationship-centred practice?

PART FOUR: Facilitator guide

Meaningful change is rarely the result of a single learning experience.

It develops through ongoing reflection, shared learning, and a willingness to see situations from different perspectives.

The way we facilitate learning today can influence the care people experience tomorrow.

Using the workbook

The ORA Scenario Workbook is designed to support facilitated learning through reflection and discussion.Each scenario unfolds over time, allowing additional context to emerge before participants are invited to reconsider their initial assumptions and interpretations.

Facilitators may choose to explore a single scenario in depth or use several scenarios as part of a broader learning programme.

Participants should be encouraged to discuss the scenarios from multiple perspectives, recognising that there is rarely a single "right" interpretation or response.

Creating meaningful discussion

The purpose of ORA is not to reach a single conclusion or identify a "correct" response. The value of the discussion lies in exploring different perspectives, questioning assumptions, and considering how context influences people's experiences and decisions.

Facilitators are encouraged to create a learning environment where participants feel comfortable sharing different viewpoints, respectfully challenging one another's thinking, and reflecting on how the scenarios relate to their own practice.

Where discussion naturally moves towards solutions, consider first exploring how participants reached their conclusions and what assumptions may have influenced their thinking.

Facilitating a session

The ORA scenarios are flexible and can be used in a variety of settings, depending on the purpose, available time, and learning needs of the group.

Suggested discussion flow

1. Introduce the purpose of the session and encourage participants to remain open to different perspectives.
2. Read the scenario together.
3. Allow time for individual reflection before inviting discussion.
4. Explore the scenario as additional context emerges.
5. Use the ORA Reflection prompts to deepen discussion.
6. Finish by considering how the learning might apply to participants' own practice.

Sessions may range from 20 to 90 minutes depending on the setting, group size, and learning objectives.

ORA can also be used to facilitate reflective discussions.

The same principles that support relationship-centred conversations with patients can also help facilitators create meaningful learning conversations with teams.

Throughout this guide, the **OPEN, REFLECT** and **ACTION** prompts are intended to support facilitation rather than provide additional questions for participants.

Scenario 1 | Cardiology Ward

Key themes

- Understanding versus agreement
- Unspoken uncertainty
- Time and environmental pressures
- Participation in healthcare conversations
- Understanding that develops over time

Facilitator note

Discussions often begin by focusing on what the consultant or Wiremu could have done differently. Allow participants time to explore these perspectives before broadening the discussion to consider the influence of the ward environment, competing priorities, and the presence of whānau.

If participants begin looking for a single "right" response, encourage them to consider how the interaction may have been experienced differently by each person involved. The aim is not to decide who was right, but to explore how understanding develops over multiple conversations.

Guiding the discussion

- At what point might someone reasonably conclude that this conversation had been successful?
- What might lead another person to see it differently?
- How did the realities of a busy ward influence the interaction?
- What opportunities and limitations did they create for everyone involved?
- Where do you think responsibility for shared understanding sits in this conversation?
- How might different people answer that question?

Facilitation tips

OPEN | Relationship first

If the discussion focuses primarily on communication or clinical decisions, invite participants to consider how the relationships between Wiremu, Mere, and the clinical team may have influenced what was said, and what remained unsaid.

REFLECT | Understand what matters

After participants have read the additional context, encourage them to revisit their initial impressions. Explore what changed, what surprised them, and how the additional information influenced their understanding of the interaction.

ACTION | Plan together

Towards the end of the discussion, encourage participants to identify one realistic change they could make in their own practice or team that might create more opportunity for shared understanding during similar interactions.

Scenario 2 | General Practice

Key themes

- Access and continuity
- Delayed help-seeking
- Hidden context
- Trust over time
- Competing demands within primary care

Facilitator note

Participants may initially focus on Hana's decisions, such as delaying care or not disclosing everything during the first appointment.

Allow time to explore these perspectives before broadening the discussion to consider how access to care, continuity, time pressures, and previous healthcare experiences may have influenced what Hana chose to share.

If the discussion centres on individual responsibility, encourage participants to consider how trust often develops over multiple interactions rather than within a single consultation.

Guiding the discussion

- At what point did your understanding of Hana's situation begin to change?
- What prompted that shift?
- How might continuity of care influence what people choose to disclose over time?
- What assumptions could easily be made in a short consultation?
- How might those assumptions influence clinical decisions?

Facilitation tips

OPEN | Relationship first
If participants focus primarily on Hana's symptoms or treatment, encourage them to explore how the relationship between Hana and the GP developed across both consultations and what helped create greater openness.

REFLECT | Understand what matters
Invite participants to consider what information remained hidden during the first consultation, why it may not have been shared, and how the additional context changed their understanding of the situation.

ACTION | Plan together
Towards the end of the discussion, encourage participants to identify one realistic change they could make in their own practice or team that might create more opportunities for people to raise concerns that do not emerge during an initial consultation.

Scenario 3 | Cardiology Outpatient Clinic

Key themes

- Assumptions and documentation
- Engagement versus attendance
- System navigation
- Competing interpretations
- Clinical risk and understanding

Facilitator note

Participants may initially focus on Sione's missed appointments or apparent lack of engagement.

Allow time to explore these perspectives before inviting discussion about how documentation, previous interactions, and assumptions may influence expectations before a conversation even begins.

If participants conclude that the situation is primarily about non-attendance, encourage them to consider what information only became visible once Sione had the opportunity to share his perspective.

Guiding the discussion

- How did the information recorded in the clinical notes influence expectations before the conversation took place?
- At what point did your understanding of Sione's situation begin to change?
- What contributed to that shift?
- How can clinicians remain open to new information while still making appropriate use of documentation and previous clinical history?

Facilitation tips

OPEN | Relationship first
If discussion focuses on attendance or compliance, encourage participants to explore how the nurse specialist created space for Sione to explain his experience before drawing conclusions.

REFLECT | Understand what matters
Invite participants to consider how documentation supports safe care while also recognising that it may not capture the full story.

ACTION | Plan together
Towards the end of the discussion, encourage participants to identify one realistic way they or their team could remain open to new information, even when previous documentation appears to tell a clear story.

Scenario 4 | Respiratory assessment

Key themes

- Clinical priorities and life realities
- Shared decision-making
- Caregiving responsibilities
- Feasibility versus ideal care
- Negotiating uncertainty

Facilitator note

Participants may initially focus on whether the recommended treatment was clinically appropriate or whether Kararaina should have accepted the admission.

Allow time to explore these perspectives before broadening the discussion to consider how family responsibilities, practical realities, and competing priorities influence healthcare decisions.

If the discussion becomes polarised between "best practice" and "patient choice," encourage participants to explore how shared decision-making can acknowledge both clinical expertise and the realities of everyday life.

Guiding the discussion

- At what point did the conversation shift from deciding what was clinically recommended to exploring what was realistically achievable?
- How can clinicians balance clinical priorities with the practical realities people face outside the healthcare setting?
- What does meaningful shared decision-making look like when there is no perfect solution?

Facilitation tips

OPEN | Relationship first
If discussion focuses primarily on the clinical decision, encourage participants to consider how creating space for Kararaina to explain her circumstances changed the direction of the conversation.

REFLECT | Understand what matters
Invite participants to explore the competing responsibilities, priorities, and pressures influencing both Kararaina and the clinician, and how these shaped the decisions being made.

ACTION | Plan together
Towards the end of the discussion, encourage participants to identify one realistic way they could better explore what is practical and achievable when developing care plans with people and whānau.

Scenario 5 | Shared expertise

Key themes

- Shared expertise
- Continuity of care
- Preserving knowledge across healthcare encounters
- Consistency of care across teams and settings
- Partnership beyond the individual consultation

Facilitator note

Participants may initially focus on the clinical management plan or suggest changes that could be made to Tama's treatment.

Allow time to explore these ideas before broadening the discussion to consider the wider issue being raised by the whānau. The central question in this scenario is not whether a better plan is needed, but how shared knowledge can be recognised, trusted, and consistently applied across different clinicians, teams, and healthcare encounters.

If participants begin looking for clinical solutions, encourage them to step back and consider what the scenario reveals about continuity of care and the challenges of preserving shared understanding over time.

Guiding the discussion

- What challenges were the whānau describing beyond Tama's clinical condition?
- What systems or processes help ensure that important knowledge is recognised and carried forward when different clinicians become involved?
- How can healthcare teams build on years of shared learning rather than repeatedly starting again?

Facilitation tips

OPEN | Relationship first
If discussion focuses primarily on the management plan, encourage participants to consider how the consultant created space for the whānau to raise concerns that extended beyond the current admission.

REFLECT | Understand what matters
Invite participants to explore how clinical expertise and lived experience complemented one another throughout the conversation, and what this revealed about continuity of care.

ACTION | Plan together
Towards the end of the discussion, encourage participants to identify one realistic way their own team or service could better preserve shared knowledge so people and whānau do not have to repeatedly retell their story.

Appendix: How ORA relates to other frameworks

This section positions ORA alongside other frameworks used in Aotearoa healthcare. It's most relevant if you're evaluating ORA against, or planning to use it alongside, an existing framework, rather than something you need before working through the scenarios.

ORA has been developed alongside, and informed by, existing frameworks that support culturally safe and relationship-centred healthcare in Aotearoa, including Te Whare Tapa Whā, developed by Sir Mason Durie in 1984,[5] the Meihana Model, and the Hui Process. This work also sits within a wider body of literature on Māori models of relational health, which has consistently found that Indigenous frameworks grounded in relationship and collective wellbeing offer something that individually-focused clinical models do not capture on their own.[17]

These frameworks have each made a significant contribution to healthcare practice. The Meihana Model provides clinicians with a structured framework for clinical assessment, drawing on Te Whare Tapa Whā to guide what should be considered when working with Māori clients and whānau. The Hui Process provides a structure for how a clinical encounter can unfold, from initial engagement through to closing, to support culturally safe interaction with Māori patients.

ORA offers a complementary resource alongside these frameworks and the important work they do, shaped by a slightly different question.

Many frameworks focus on a single conversation: how to open it well, what to cover, how to close it. ORA starts from a different observation, that a conversation can be conducted well, with genuine warmth and respect on both sides, and understanding can still be incomplete. Not because anyone did something wrong, but because people don't always share everything in a first conversation, in a busy environment, or before trust has had time to develop. A nod can mean genuine agreement, or it can mean not right now. Both look the same in the moment.

ORA invites clinicians to hold that possibility lightly, without treating it as a signal that something has failed. It encourages noticing rather than diagnosing (small cues that understanding may still be forming) and offers ways to leave space for it to continue developing, in this conversation or a future one.

This shapes what ORA offers that is different:

- **It treats understanding as something that develops over time,** not something achieved or missed within a single encounter. Several of the scenarios in the Scenario Workbook show this directly: the fuller picture only emerges in a later conversation, once trust has had space to build.
- **It focuses on noticing, not evaluating.** Every scenario in ORA depicts clinicians and whānau engaging thoughtfully and in good faith. The learning centres on recognising the moments (a pause, a quiet nod, a question not quite asked) that may indicate there is more still to understand.
- **It is designed for use across healthcare settings and populations,** informed by te ao Māori perspectives while supporting relationship-centred practice more broadly.

We encourage those using ORA to also engage with the Meihana Model and the Hui Process, particularly where working directly with Māori patients and whānau, for the depth and specificity they bring to that work.

Glossary

Ora	Health, wellbeing, and life itself. In this framework, the word also stands for Open, Reflect, Action, a deliberate double meaning.
Ako	Reciprocal learning. The idea that everyone in a conversation is both a learner and a contributor, rather than knowledge flowing only one way.
Hinengaro	Mind; the mental and emotional dimension of wellbeing.
Iwi	Tribe; a group descended from a common ancestor.
Karakia	Prayer or incantation, often said before or after treatment, procedures, or meals.
Kaumātua	Elders; may provide spiritual or cultural leadership and guidance for whānau.
Kaupapa	A guiding purpose, principle, or set of values underpinning an approach or plan.
Kotahitanga	Unity, togetherness, a sense of collective purpose.
Marae	A communal meeting ground and complex of buildings that serves as a focal point for a hapū or iwi.
Mate	Illness or death.
Mate Māori	Illness understood to have a spiritual or cultural cause, sometimes linked to a breach of tapu or ancestral displeasure.
Mate Tangihanga	Death and dying, viewed as a spiritual transition rather than an end.
Mokopuna	Grandchildren.
Noa	Ordinary, free from restrictions – the state achieved through rituals such as washing hands or karakia.
Pounamu	Greenstone; a taonga often carried or held for comfort and spiritual connection.
Rangatahi	Young people.
Taha	A side or dimension (as in the four taha of Te Whare Tapa Whā: wairua, hinengaro, tinana, whānau).
Tangihanga	Funeral rites and rituals, often involving large gatherings at the marae.
Taonga	Treasured objects, such as pounamu or photographs, that may provide spiritual comfort.
Tapu	Sacred, restricted, or spiritually potent.
Te Whare Tapa Whā	A wellbeing model developed by Sir Mason Durie, describing health as four interconnected dimensions – wairua, hinengaro, tinana, and whānau.
Tinana	The body; physical health.
Tūpāpaku	The body of a person who has died.
Wairua	Spirit; the spiritual dimension of a person's wellbeing.
Wairuatanga	Spirituality. The spiritual dimension of a person's wellbeing.
Whakamana	To recognise, uphold, and give authority to the strengths, knowledge, and experience of another person.
Whakapapa	Genealogy; lines of descent connecting a person to their ancestors.
Whaka-whanaungatanga	The active process of building connection and relationship, often used to describe taking time to connect personally before moving to the purpose of a conversation.
Whānau	Family, in the broadest sense. Not limited to immediate or biological family.
Whanaungatanga	Relationships, kinship, and the connections between people.
Wharenui	The main meeting house on a marae, used in Te Whare Tapa Whā as a metaphor for wellbeing.

Evidence base and key references

Citations in the "Why ORA" section are given in full. Elsewhere in this guide, citations are numbered and correspond to the sources listed below.

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Supporting relationship-centred healthcare through reflection, understanding, and partnership.

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