Working in the Gorse: Criticality in Rehabilitation Healthcare Education in Aotearoa|New Zealand

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Abstract

Globally, the dominant forms of rehabilitation healthcare education take a positivistic, scientific approach that views the body mechanistically, disability as a deficit, and Western worldviews as superior to others. However, privileging these approaches occludes other important ways of understanding bodies, health, and rehabilitation. In response to these limited yet pervasive ways of constructing our disciplines, we urge rehabilitation healthcare educators to enact "criticality." A critical perspective helps students think critically about their learning at a political and sociocultural level. As evidence of how this criticality opens new and valuable avenues for rehabilitation healthcare education, we point to existing research in global health along with our own experiences attempting–and often struggling–to enact criticality in our teaching at the tertiary level in Aotearoa |New Zealand.

Key words: Criticality, rehabilitation professions' education, New Zealand, healthcare pedagogy

INTRODUCTION

In the title, we write Aotearoa|New Zealand to run against convention by placing a line between Aotearoa and New Zealand to emphasise that these are not two names for the same country but two distinct countries occupying the same land. This notion is somewhat aligned with Came, Warbrick, McCreanor, & Baker (2020) who developed an allegory of decolonising the New Zealand health system (Came, et al, 2020). They referred to white, European settlers' introduction of an invasive and extremely thorny shrub, gorse, that colonised hills (grazing areas) and forests in Aotearoa|New Zealand. Gorse has now proliferated across the country and creates a prickly and unpleasant environment. Came et al. (2020) used gorse infested land as a metaphor for the inequitable healthcare system. They focused the role of the coloniser as working from being in the gorse (a colonised, inequitable health system) and that the colonised worked on the ngahere (indigenous forest systems) in Aotearoa|New Zealand. This metaphor illustrates how colonisation has permeated various aspects of society, including healthcare. A key feature in the production of a colonised health care system is, of course, a colonial health professional education system, rehabilitation being a significant part of it. Rehabilitation professions like audiology, occupational therapy, physiotherapy, and speech and language therapy are colonial artefacts (Pillay, et al., 1997; Christopher, et al, 2021, Cobbing, 2021, van Vuuren, 2022; Davis & Came, 2022).

In this Viewpoint article, we position our views as a product of our identities, some aspects of which we review here: Five authors were born outside of NZ and are non-Indigenous Aotearoa|New Zealand residents/citizens. Of the two Aoteraroa | New Zealand born authors, one is Māori and the other Pākehā. Three authors trained as rehabilitation professionals and practice as educators in Aotearoa | New Zealand. These conversations have been informed by two other participants, both women, one white (Pākehā, NZ citizen) public health academic-activist in anti-racism, and an Indigenous (Māori) rehabilitation professional.

DEFINING CRITICALITY

"Criticality" is used to refer to the ability to think critically at a political and a sociocultural level. We argue that more effort be made to develop students' criticality in the rehabilitation professions, particularly audiology, occupational therapy, physiotherapy, and speech and language therapy. The training for these professions implicitly aims for a scientist-clinician who "treats" the "disabilities" and helps "patients" become "better." We put key terms in quotation marks to signal how the critical perspective that we advocate for, questions the very vocabulary that underpins our disciplines and their pedagogies. Furthermore, the students who are accepted in these programmes have often succeeded in

positivistic science backgrounds (Brown, et al., 2008) that narrowly locate "criticality" within the enclosed environment of laboratory-like conditions.

In laboratory-like research, the objective, externally located researcher ensures that extraneous variables are removed as much as possible and controlled when they cannot be removed. Knowledge produced in this way is seen as generalisable to others (Pillay, et al, 2023). Typically, rehabilitation programmes extend this type of thinking into the understanding of clinical practice (Lurch, et al., 2023; Cobbing, Kayes & Papadimitriou, 2023). Students, therefore, may never have considered the possibility that this positivistic paradigm—and the associated discourses about diagnosis, treatment and reducing disability—is not the only way to consider rehabilitative health. Outside of the laboratory, of course, no variable is extraneous, and few can be controlled. It is essential to train in ways that enable critical coping with complexity and frame it meaningfully and culturally.

Criticality Challenges "Deficit" Training

Standard rehabilitation encompasses conventional approaches used in speech-, occupational-, and physio -therapy to help individuals recover or maximise their functional abilities from injuries, illnesses, or disabilities. For professions like occupational or physiotherapy, standard rehabilitation may typically include exercise therapy to improve strength and flexibility, manual therapy techniques, and the use of physical modalities like heat or electrical stimulation. Patient education about the condition and self-management strategies is also key. These approaches generally follow established protocols and evidence-based practices; if consistent, practice and gradual progression will lead to improved function. While standard rehabilitation approaches have been widely used for decades, some researchers and clinicians have begun to question their efficacy and underlying assumptions.

"Standard" rehabilitation healthcare education socialises students into believing that diagnostic and intervention practices are universally valid despite their limitations. This approach tends to confine rehabilitation practice into working with discrete body parts and to privilege technical prowess over interpersonal connection and holism (Nicholls & Gibson, 2010). Accordingly, rehabilitation practitioners are positioned as experts, as 'saviours' helping the pathologized minority client (Pillay & Kathard, 2018). This "standard" approach is advanced through its tertiary and professional education programmes that divert, suppress, and co-opt challenges from alternative discourses.

This standard approach limits the kinds of students who enter these professions. For instance, one aspect of university selection criteria (for most rehabilitation programmes) involves demonstrating evidence of prior academic success. This

requirement tends to implicitly prejudice programmes towards selecting students who have socioeconomic backgrounds where academic performance is expected and modelled, while being used to reading and intellectualizing, as well as being more likely to have the security of financial resources available (Davis & Came, 2022). This observation is not intended to imply that students would directly spend money on improving their grades, as the reality is more subtle: people from higher socioeconomic backgrounds tend to perform better in academic courses because they know how to play the game, have multiple role models of academic success, and are used to reading and intellectual debate. They are also more likely to have the financial resources to focus on studying, and to feel secure in their living environment (Manstead, 2018).

Focus on Positivistic Thinking

Rehabilitation programmes tend to require students to have studied in positivistic scientific disciplines such as anatomy and biology, which reduces the likelihood of those with backgrounds in other disciplines. Given that criticality is more commonly taught in the arts and humanities, this preference for students from positivistic scientific disciplines diminishes the likelihood of having a student body that questions the curricula of rehabilitation healthcare programmes.

Standard rehabilitation healthcare curricula promote a professional culture that divides *what* practitioners do from *who* they are and separates the health conditions from the people who experience them. In this context, rehabilitation health professionals' pedagogy socialises learners into becoming caring helpers, a role that sounds benign but one that indelibly shapes the flow of power in rehabilitation practice. Training programmes are based on either established/declared or generally acceptable international standards (McIlroy & Storbeck, 2011). For example, professional education for audiologists focuses on the measurement, classification, and treatment of hearing impairments (disability) and deafness. In setting up these practices, rehabilitation education programmes position audiologists as the caring experts over people with hearing disabilities and the deaf. On the other hand, the Deaf culture celebrates deafness as a cultural marker and not as a disability. Furthermore, the negotiation of identity is complex for Māori who are Deaf (Faircloth, et al, 2007; King & Cormack, 2022). These disparities in interpretation highlight the inadequacy of an uncritical epistemology that, due to its positivistic lens, focusses only on the measurable "hearing loss." Without criticality, this approach fails to acknowledge the importance of understanding the sociocultural context of deafness. In this approach, deafness is viewed as a disability because of social and political decisions that prescribe and enforce both "normal" ability and anything that deviates from that norm as a "disability" (Putnam, et al, 2022; Skelton & Valentine, 2017).

Agency in Rehabilitation Professions' Education

Higher education conceives the agency of people by positioning them as consumers or clients. This consumerist framework appears to position people as actively engaged in transacting their hearing health care. However, the diagnostic process of classification, diagnostic labeling, and so forth attempts to compel the individual into taking responsibility for their identity as disabled. Conversely, professional education programmes focus on training practitioners to define being human relative to possessing "broken" communication (including hearing), movement, occupational and other mechanisms like eating/drinking. When the goal is to be closer to "normal" to live in the world, then rehabilitation professional education actively disengages with the political conditions that create disability (Pillay, et al, 2024). In this way, the subject matter (communication, hearing, movement, occupation) may be lost in a quagmire of deficit pathologisation, the cacophony of reductionist science and the balm of saviourism.

The critique of "standard" rehabilitation healthcare education highlights significant flaws in the existing system, emphasizing its inclination towards a positivistic, technical, and reductionist approach. This perspective underscores the limitations of focusing solely on measurable outcomes and body parts, often at the expense of holistic, interpersonal, and sociocultural dimensions. The analysis suggests that such an education system favors students from higher socioeconomic backgrounds and scientific disciplines, potentially marginalizing those with diverse perspectives and backgrounds. However, an alternative viewpoint might argue that the emphasis on technical expertise ensures a high standard of care, grounded in scientifically validated practices. This approach might be seen as necessary for maintaining rigorous and consistent professional standards, which can ultimately benefit patients through reliable and effective treatments. While the critique is valuable in highlighting areas for improvement, the strengths of the existing system in providing robust, evidence-based care should not be overlooked. Integrating both perspectives could lead to a more balanced and inclusive approach to rehabilitation healthcare education.

Criticality Attends the Wider Conditions That Make Us Human

Without criticality, rehabilitation education programmes also fail to address the wider conditions that shape the humans who seek rehabilitation healthcare. Like occupational therapy's overt reclaiming of 'occupation' within frameworks such as PADL (the Political Activities of Daily Living framework; Kronenberg, Pollard & Sakellariou, 2011), communication (hearing) and movement can also be considered as critical points of entry to reimagine rehabilitation professionals' education. In an example from physiotherapy, the first year of most training

courses focuses heavily on the study of anatomy, physiology, kinesiology, pathology, psychology, and biomechanics. This core knowledge socialises the student to the idea that they must treat the body-as-machine (Nicholls, 2017). This central professional edifice is then bolstered repeatedly throughout the professional's life by further episodes of training; systems of regulation, assessment, and treatment practices; forms of language; and practice standards.

The Persistence of Western Biomedical Paradigms in Rehabilitation Sciences

Historically, the western idea of the body-as-machine with all its attendant concerns for objectivity and detachment, pathocentrism and supposed value-neutrality was seen as a necessary part of becoming a legitimate and orthodox profession (Nicholls, 2017). But rehabilitation practitioners rarely acknowledge the degree to which their willing acceptance of these approaches actively marginalises other ways of thinking and practising. In recent years, several scholars have argued against turning a blind eye to the many other ways people in society experience notions of health and illness, arguing that this monocultural view of health amounts to the celebration of a very particular kind of white privilege (Gibson, Nicholls, Synne-Groven & Setchell, 2018; Nicholls 2022). The professions' collective response, however, has been to maintain their traditional anchoring to Western biomedicine whilst opening to only a smattering of new perspectives (Mtima-Jere, et al., 2023).

In a related example, speech and language therapy (SLT) neglects the richness of humanity in a different way. Not too long ago, SLT introduced a new diagnosis, "Developmental Language Disorder" (DLD) into the curriculum. But the diagnostic process for DLD involves using norms generated from monolingual, English speaking populations (Pillay, 2001). And yet, non-English, and multilingual speakers also risk being ascribed this disorder. Both students and educators currently lack the criticality to question this narrow construction of language development. And when SLT specialists assume that their discipline's labels describe objective facts, they miss the opportunity to think critically about what norms those labels reinforce and what consequences those norms hold for the people implicated.

Criticality in Rehabilitation Education

With training in criticality, students would consider colonial histories that contribute to the over-representation of Indigenous children under this label, and whether the introduction of a new disorder is likely to result in an over-representation of marginalised children (Pillay, Quigan & Kathard, 2023). Considered through a critical lens, a diagnosis like this is not descriptive but normative, which informs the potential for assessment and diagnosis. However,

the norms remain unquestioned in the curricula, and the responsibility for pursuing and maintaining a rehabilitation programme falls to the client and their family. When considering the wider context, rehabilitation is positioned to improve therapist practice and support the child/children to communicate in a way that fits with the dominant cultures. This kind of rehabilitation rarely, if ever, provides the opportunity to critique how the norm is derived from a colonial context or to explore structural inequities that land unevenly on diagnosed individuals.

Configured thus, through both selection and curricula, rehabilitation healthcare education perpetuates the very inequalities that our disciplines and practices profess to remedy (Quigley, et al., 2023). It can be very difficult to justify change, however, and the introduction of any new material is confronted by an interlocking matrix of bureaucratic factors which block or drain away the time and energy required for innovation. The oft heard sentiment: "That would be nice to include, but we don't have time for all the things we need to teach as it is," epitomizes bureaucratic fettering. This barrier is difficult to overcome. As a result, rehabilitation healthcare education programmes, like all other colonised higher education programmes (Ensucho, 2023) tend to be highly conservative, especially when located in neo-liberal universities.

To round off this article we now turn to the unique historical and cultural context of Aotearoa | New Zealand, the land in which we live and work. As in many other settler-colonial countries, Māori, the Indigenous people of this land, have reclaimed significant political, economic, and cultural space in most societal institutions. This offers a unique perspective on health rehabilitation education because Indigenous in-roads are necessarily critical of existing systems.

CRITICALITY ALIGNS WITH INDIGENOUS APPROACHES

Decolonising rehabilitation professions in countries like South Africa began in the early 1990s (Kathard & Pillay, 1993; Pillay & Kathard, 2015). While the term decolonisation has many implications for tertiary teaching, one core tenet involves centering Indigenous People's epistemologies and methodologies. Rehabilitation healthcare education could learn from these efforts to prioritise non-Western knowledges and methods. But this too must be done critically, otherwise decolonising the curricula risks becoming an empty gesture that tacitly reinforces the problematic status quo described above. On this topic, our perspective as tertiary educators in Aotearoa|New Zealand offers important insights.

Decolonisation and Rehabilitation Healthcare Education in Aotearoa | New Zealand

The current nation state is referenced to the Treaty of Waitangi/Te Tiriti o Waitangi, the foundational document of the colonial state of New Zealand. Te Tiriti established the terms and conditions of non-Māori settlement, reaffirmed Māori sovereignty (tino rangatiratanga), and has been consistently (inter-generationally) breached by settler governments. The outcome of these breaches are systemic inequities in social, economic, and health outcomes for Māori (Brown & Bryder, 2022). Te Tiriti remains an important political agreement that continues to hold a central place in public policy and in academic and health practices today (Waitangi Tribunal, 2023).

In the context of criticality, mātauranga Māori (Māori knowledge)—which comes from a unique ontological and epistemic position—has the potential to resist, challenge and transform educational practices and ultimately the healthcare professions themselves. Mātauranga Māori, for example, assumes people and the natural, physical, spiritual, and other worlds to be interconnected (Te Ahukaramū Charles Royal, 2003). Ideas like this present a profound challenge to traditional Western framings of rehabilitation healthcare education, which tends to see the body in isolation from its surroundings. The growing influence of mātauranga Māori in Aotearoa|New Zealand—and of Indigenous knowledges worldwide—requires all rehabilitation educators to acknowledge the consequences of colonial histories in contemporary inequities, how students and their backgrounds are informed by these histories, and the need to navigate these complex relations in their professional practices. This context makes Aotearoa|New Zealand an important case study in the global debate about the role of decolonisation in rehabilitation healthcare education.

Integrating Indigenous Approaches in Rehabilitation Curricula

In principle, integrating indigenous approaches in rehabilitation curricula may sound positive. In Aotearoa|New Zealand, for instance, some rehabilitation programmes are attempting to undergird their biomedical curricula with a multi-layered application of Te Tiriti o Waitangi (Pillay, et al, 2023). This is, in theory, a genuine effort, but is this sufficient to enable students to develop the criticality that we believe is important? Certainly, there were many alternatives - even in the context of a more Indigenous approach to health and illness, programmes could have built their curricula with Te Ao Māori (the Māori world) as the founding ontological framework. But this would have meant abandoning the nexus that currently legitimises programmes, viz. the pathocentric curriculum; the emphasis on Latinate descriptions of body parts; the concept of the therapist as ‘doer’ and the patient as the one being ‘done to;’ the objective value placed in enlightenment logic and reason; and other networks of power relations hidden

within Western approaches to health and illness. At best this nexus can only admit indigenous practices that integrate (i.e. support) in some way existing ideologies. The 'adding in' of Indigenous content is a compromise because it allows the rehabilitation professions to retain their bio-centric worldview whilst providing a tokenistic nod towards the Indigenous other and virtue-signaling an apparent honouring of Te Tiriti o Waitangi.

Incorporating Māori Knowledge into Course Content

Integrating mātauranga Māori into rehabilitation course design involves incorporating Māori knowledge, values, and perspectives to enhance the educational experience and outcomes for students. This approach starts by acknowledging the unique worldviews and holistic understanding of health and well-being within mātauranga Māori. For instance, incorporating principles such as the concept of hauora (holistic health) can help students appreciate the interconnectedness of physical, mental, spiritual, and social well-being in rehabilitation practices.

Course content could include traditional Māori healing practices and concepts, such as rongoā (traditional medicine) and whakapapa (genealogy), to provide students with a broader perspective on health and recovery. Collaboration with Māori practitioners and iwi (tribes) can ensure that the integration is respectful and accurate, creating opportunities for students to engage directly with these traditional knowledge holders.

Furthermore, incorporating Māori perspectives in case studies and practical exercises can help students understand the cultural contexts of rehabilitation and the importance of culturally responsive care. This approach promotes a more inclusive and holistic education, preparing future practitioners to work effectively with diverse populations and to challenge conventional paradigms within the field of rehabilitation.

There is no doubt, though, that many academics, clinicians, educators, and researchers are exploring ways to think otherwise. And this is perhaps not surprising, because the traditional foci for rehabilitation – the body, speech, movement, touch, language, exercise, sound, light, music, heat and cold – *ought* to provide boundless ways to engage with Indigenous epistemologies. So, it is interesting to follow how educators are beginning to ask what values and assumptions are embedded in the Western scientific approach to practice; which ideas are centred, and which ideas are displaced; whose voice has been heard, and whose is marginalised.

If rehabilitation healthcare programmes really want to embrace Indigenous epistemologies, then they must go beyond simply adding Māori words to existing

courses and instead reimagine what an entire educational programme would function like with Te Ao Māori as its ontology, actualised through mātauranga Māori as its epistemology. This critical examination of rehabilitation practices and the integration of Indigenous epistemologies leads us to a crucial juncture, where we must consider the broader implications for global health and education.

CONCLUSION

So, what does all this mean for those invested in global health and education? Critically, we must remain constantly vigilant that what we teach contains the necessary complexity. It is essential that knowledge is not dumbed down, that the right "words" are used to demonstrate complexity of thought, that we eradicate academic bullying or gaslighting about onto-epistemologies. We must be wary of quick and simple pedagogical solutions, which too often mask the complexity of undoing harmful ideologies and, in so doing, perpetuate inequities in rehabilitation healthcare. Also, there is a need to be steadfastly critical of our own work and our teaching practices—especially of our new ideas and our seemingly innovative changes—because the guise of novelty and the mirage of progress can be a seductive but ultimately destructive combination. We must, as one of the persons who consulted and critiqued this paper says regularly, "go to work in the gorse."

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