The student narrative of undergoing academic difficulty and remediation in a medical programme: Indigenous Māori and Pacific Admission Scheme (MAPAS) and international student perspectives at The University of Auckland

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ABSTRACT

AIMS: To understand the medical student perspective and experiences of academic difficulty and remediation in years’ 2–6 at The University of Auckland (UoA), Aotearoa New Zealand, who were admitted via the Indigenous Māori and Pacific Admission Scheme (MAPAS) and international student pathways.

METHODS: A qualitative study which undertook one-on-one, semi-structured interviews using case study as the research method within Kaupapa Māori and Pacific research frameworks. Two student groups were interviewed during 2017: MAPAS and international medical students. An email invitation was sent to all students, inviting those who had failed a year, or at least one examination, assessment, module or domain in UoA Medical Programme during 2014–2016 to participate in the study. Interview transcripts were thematically analysed with an inductive approach.

RESULTS: Fourteen medical students at UoA were included in the study, with ten from MAPAS and four from the international student admission pathway. There were six major themes identified. Three themes related to academic difficulty: the set curriculum, the hidden clinical curriculum and life complexities. Three related to the student perspectives of remediation: the impact of MAPAS support, enhanced resilience (particularly the MAPAS cohort) and stigmatisation from failing.

CONCLUSIONS: This study has investigated the MAPAS and international medical student experience of academic difficulty and remediation at UoA. The student dialogue offered a rich insight to deepen our understanding into the remediation process to ensure it is not only culturally safe but also fit for purpose. Tertiary institutions that offer undergraduate medical education can (and should) better support their at-risk medical student cohorts.

Students who under-achieve in medical school are more likely to struggle academically and professionally as graduate doctors. The University of Auckland’s (UoA) Medical Programme in Aotearoa New Zealand offers remediation to students who have failed to demonstrate that they can achieve the required academic standard. Globally, remediation practices vary. In UoA setting, remediation is defined as a formal repeat opportunity to demonstrate the specific standards (academic or professional) which were not previously met within a clinical or examination setting. Remediation may include a few weeks of additional study and assessment, repeating a single test, or an entire year, with additional academic and pastoral support. Further, if a medical student within UoA is identified as being in academic difficulty but is not required to undertake additional assessments they are identified by a “tag”. A student who is “tagged” is offered additional resources and assistance to support academic success.

During 2013 and 2014, 17.7% of medical students in years 2–5 were offered remediation at the UoA, with internationally admitted and Indigenous Māori and Pacific Admission Scheme (MAPAS) students most at-risk. UoA has focused recent
efforts on improving the health and wellbeing of medical students, including reducing the need for high-stakes assessments (which are associated with poor psychological wellbeing). With this in mind, the student experience of how the medical curriculum is delivered, assessed and remediated within high-risk groups at UoA is vital to optimise their educational experiences, maintain their health and produce competent doctors.

In New Zealand, development of the health workforce to reflect society is necessary to improve health equity for Indigenous Māori and Pacific peoples. UoA continues to support equitable health workforce training through Vision 20:20, in which at least 30% of students are admitted to their Medical Programme from Indigenous Māori or Pacific ancestry through a social justice/equity pathway called MAPAS. MAPAS is more than a selection pathway, as it offers culturally appropriate academic and pastoral student support to promote student success. MAPAS students are generally admitted with a lower Grade Point Average (GPA), come from higher deprivation and are more likely to be the first in their family to attend tertiary education, comparative to their non-MAPAS counterparts.

International students are also more likely to require remediation in the UoA Medical Programme, particularly in their clinical years. Within the UoA international student cohort in 2013–2014, 81% had English as a second language which may influence academic outcomes. Furthermore, international students encounter other difficulties when training in medicine, including social isolation and financial pressures, which may contribute to their higher rates of remediation comparative to domestic students at UoA.

Remediation is a well-researched area, however the at-risk medical student narrative of what helps and hinders the remediation journey is largely absent. The aim of this study was to understand the medical student perspectives and experiences of academic difficulty and remediation in years’ 2–6 at UoA who were admitted via the MAPAS and international student pathways.

Methods

A qualitative, semi-structured interview approach was utilised. As it relates to Māori and Pacific students, Kaupapa Māori and Pacific research paradigms were incorporated into a case study framework. Case studies, as a research method, are useful when the focus is on a contemporary phenomenon within a real life context, as it seeks to understand phenomena using inductive reasoning. Kaupapa Māori aims to ensure that the research is “safe” for Māori and is likely to lead to a positive benefit for Māori whānau and communities. This approach is explicit in the inclusion of Māori leadership, and in the need to address issues of power within the research process. This study included an experienced Kaupapa Māori researcher with an academic leadership role in MAPAS (initialled EC). The Pacific research paradigm of Talanoa was broadly incorporated into the study design via the inclusion of a Pacific researcher (SW) in the leadership of the overall study. We expect this approach to be beneficial for international students, although not specifically targeted, due to the methodological focus on addressing structural factors associated with power, privilege and racism.

It is acknowledged that this research was led by a female insider (emerging) researcher (SW), who is of Pacific (Samoan) ancestry, and who graduated from UoA medical programme via the MAPAS entry pathway in 2011. The authors of this study were staff of the Faculty of Medical and Health Sciences at UoA at the time of data collection leading to the mutual interest in this topic, and experience on the board of examiners may have led to preconceptions of international and MAPAS remedial students. Ethics for the study was granted from the UoA Human Participants Ethics Committee (UAHPEC) in 2017 prior to data collection.

The participants in the study were recruited by an email invitation for a one-on-one interview that was offered to the total medical student cohort at UoA during 2017. Students who responded to the invitation were checked for inclusion criteria: all students who had failed a year or at least one examination, assessment, module or domain during 2014–2016. Exclusion criteria included a student with personal or professional affiliation with either interviewer (initialled hereafter as SW or SS) or any students who were not admitted via the MAPAS or international pathways.

The interview was confidential, voluntary, and located in a private room on the university campus. Participation or non-participation had no influence on eligible participants’ clinical teaching or assessment. Two interviewers were used, either SW or SS (of Middle Eastern ancestry). A series of open-ended questions as per a semi-structured approach were used to guide the interview focused on experiences of medical
education (including their experience of failure and remediation). See Appendix 1 for the specific question series. The interview process included whakawhanaungatanga (a Māori process of establishing relationships), with a prayer and koha (gift) offered to participants. The interview was audio-recorded with permission.

The audio interview recordings were transcribed verbatim by the lead researcher (SW) manually. The typed transcripts were de-identified to maintain confidentiality and offered to participants for member checking. SW then undertook the three-step process of thematic analysis with an inductive approach.\(^{19,20}\) Firstly, SW familiarised herself with the data by reading and re-reading the transcripts. Secondly, SW manually assigned preliminary codes to describe the data content and further categorised these into a coding tree. Patterns and themes across the codes within the 14 interviews were analysed, resulting in the naming of the initial themes. The initial themes were then reviewed and refined by a secondary researcher (JY) before being brought to the full research team (WB, EC, JY and SW) for rigorous assessment and analysis. A commitment to meaningful and respectful dialogue among the co-authors was undertaken during the data interpretation and analysis, which required multiple robust discussions. As both Kaupapa Māori and Talanoa perspectives require a non-victim blaming approach and culturally appropriate conclusions to be drawn from the data, a secondary thematic analysis of the MAPAS student transcripts were completed by EC who, with data coding, identified patterns in the resultant codes. The patterns and themes EC identified were then used to refine and restructure the initial themes. Finalised themes were defined and named collaboratively within the research team.

## Results

Twenty students responded to the email invitation. Six were excluded due to not meeting the eligibility criteria or subsequently not responding to contact. The remaining 14 were made up of four international students, five Pacific and five Māori MAPAS students with differing remediation requirements (Table 1). Interview times ranged between 21–66 minutes, with an average of 44 minutes.

Thematic analysis identified six major themes and eleven sub-themes. There were three major themes that related to academic difficulty: the set curriculum, the hidden clinical curriculum, and the student life complexities outside of medical school (Figure 1). The final three themes related to the student perspectives of remediation: the impact of MAPAS support, enhanced resilience, and stigmatisation (Figure 2). The emerging themes and sub-themes are discussed further in the subtitles below.

### Experience of Academic difficulty

The set curriculum was a factor contributing to student academic difficulty. This encompassed the high workload (including difficulty with learning medical jargon) and a perceived lack of clear expectations. For example, the students stated:

> I like thought first year was hard, second year was even more harder. And I think somebody described med [set curriculum] as being like a funnel and like a hose of information at you that pours on your face. I don't know, that's how it felt. – Participant 11 (MAPAS – Pacific)

> ...The language is very challenging for me. In my first lecture, musculoskeletal, there was so many terminologies. Trying to concentrate on screen, on the lecture what they are saying, the notes, it was just too much for me. And they were like saying these jargons and I was trying to spell them. I just put my pencil down. I realised I need to put lots of time into my studies, I need to go back and listen to lecture. Read the notes and that didn't help my depression at all. – Participant 8 (International)

> You don’t really know what the test is going to be like because each module is different and because there is no past test we can look at, we can’t get a good gauge of what they are expecting. – Participant 2 (MAPAS – Māori)

> I think in terms of being in a hospital, I didn’t really have any idea what that was like I didn’t know what my role was. – Participant 12 (MAPAS – Māori)

The hidden curriculum within the clinical environment, described as the untaught curriculum, which is culturally and environmentally learnt, was discussed by the students.\(^{21}\) There was mention of
The UoA medical programme is completed during years 2–6 with potential entry into this pathway through meeting the year 1 undergraduate or postgraduate student requirements.
Year 2 and 3 students are predominately based at the university campus.
Year 4–6 students are predominately based in clinical settings in primary and secondary care.

**Table 1:** Summary of included participants.

<table>
<thead>
<tr>
<th></th>
<th>Māori (n=5)</th>
<th>Pacific (n=5)</th>
<th>International (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex female (n)</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Repeat single test (n) (Year 2–3)</td>
<td>2</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Repeat entire year (n) (Year 2–3)</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Repeat entire year (n) (Year 4–6)</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
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**Figure 1:** Themes relating to academic difficulty.
hierarchy, negative learning environments and racism within the clinical environment.

I found if I spoke up in one to one or one to two interaction was easy but not in the crowd... I was obviously in the bottom of the hierarchy [on the ward round]. – Participant 5 (International)

I didn’t know how to prepare for things, no real role models to show me how to go down this path, so learnt the hard way, lot of sleepless nights, had chemistry assignments, worth 1% assignments, stay up all night working on those. Lots of sleepless nights. Now I realise a waste of time, I could have left it. Always stressful... what is the point and only worth 1%, should have focused more on the bigger, things, time management, knowing the most effective way I learn, I tried a whole bunch of different things.
– Participant 7 (MAPAS – Pacific)

After gen med [clinical rotation] where I had a bad experience, it was quite antagonistic, almost hostile, not a place I could go and learn medicine but had to put up a front so they wouldn’t see me as stupid. – Participant 9 (MAPAS – Māori)

Experiences of prejudice and discrimination (in the form of personally mediated racism) was also mentioned, particularly by international students with respect to the clinical environment:

I have been in situations where they prefer a local student or a native speaker to do or say something instead of like be happy for everyone to talk... Once one consultant, I was in a team with two different students, so the three of us. They would usually rotate the students between the consultants, one consultant picked the other two and never picked me to be with him. I felt that was because I wasn’t speaking much because of my language, and I don’t know, I felt because of my second language that he didn’t want me to be part of his team. – Participant 8 (International)

I would really appreciate if the university staff, the supervisors, like understand the situation of international students doing medicine in English because it is their second language. I haven’t had this personally but a couple of my friends who have been failed, failed their CSR [clinical supervisor report] or they got some reservations and the only comment is the student speaks English as a second language. I feel like this is unfair. – Participant 10 (International)

I don’t feel supported, I don’t feel encouraged. In fact, I feel prejudiced upon and that is very real. – Participant 1 (International)

I think probably within the first one or two weeks [of the General Medicine clinical rotation] there was a bad impression of me, he asked me questions, I didn’t answer, he was like look at this liver function test and he would shake his head no, so it was quite bad... He just stopped asking me questions, and the registrar started to do the same. Essentially, I felt the whole team didn’t like me, said I shouldn’t do medicine as a life role. Yeah, so he said I shouldn’t be a doctor at all. So, when I sat down with him to do my CSR [clinical supervisor report] he told me – ‘I don’t think you’re dumb but I don’t think you understand medicine that well and if you wanted to maybe you should consider another career path’. That is exactly what he said. – Participant 9 (MAPAS – Māori)

The complexity of each student’s unique circumstances, within which were multiple stressors, was apparent. These included sociocultural stressors such as family complexities, social isolation, assimilation due to acculturation, and financial stressors. Student psychological health was also affected. For example, within the sociocultural domain students mentioned:

Everything that was happening in my family, my parents, had issues, I went to stay with my partner’s family. Really affected me. Culturally I had to do things for the family and couldn’t study and stuff like that. I tried, I should have been honest in my reflection of how I was doing. – Participant 7 (MAPAS – Pacific)
There is not much understanding about the international student culture.
– Participant 5 (International)

The international student group expressed:

Also coming here, my views of life and the way I see things now are different from when I was back was home. So, this kind of widened the gap between me and my family. Like, I found it hard to connect with my family again. Like they are really strict and religious [Muslim], and conservative, so, and I’ve grown out of that. I have views for myself now. They are different. For example, I don’t wear my headscarf anymore. I’m not telling them that. – Participant 8 (International)

When I repeated fourth year it was very dark. I was very lonely. I was very lonely for many reasons. One of them was, I was away from home, I had no one...
I just felt like I lost that social support [from peers], and I couldn’t keep in contact with them because I felt like I was very inferior. Every time I contact them, I remember that I have repeated a year in medicine, so it is very hard for me to keep in touch with them... Plus I feel like me it was very important that I didn’t want to disappoint my family... – Participant 10 (International)

Due to some students coming from lower socio-economic backgrounds, financial difficulties were often discussed:

Year four [of medical school] I had to work two jobs. – Participant 2 (MAPAS – Māori)

Being there [living at home] I just couldn’t focus on my studies or anything. So, I ended up moving out, so there was less emotional stress, but more financial stress... I spoke to [MAPAS staff] about it, he was able to get me that financial hardship scholarship where I got a weekly payment and that helped a lot. – Participant 3 (MAPAS – Pacific)

We had the exact amount of money to get to my final year. So last year was really, really stressful in terms of financial situation because extending one year in medical school means that we might not have any money left to continue my final year... If I fail again it places a lot of [financial] burden on my parents. – Participant 5 (International)

Psychological health was a key area associated with difficulty within the medical programme:

I pretty much stopped turning up to hospital and then somewhere on the way maybe three or four weeks into general medicine is probably when I started to become depressed and I can’t exactly remember when, it was sort of on and off for a bit and then at some stage it became a daily thing where I really struggled to get out of bed and find motivation to do things. I was basically not in a position or mindset to even go to hospital and I didn’t really know what I was doing with medicine and whether I wanted to do it.
I think I had some ideas in my head that medicine wasn’t all my decision and that I had kind of felt the pressure to do it...
I was going to counselling at the time. I found it difficult to let people know... probably just the shame hindered [seeking help]. – Participant 12 (MAPAS – Māori)

It just makes me very stressed to do another OSCE [Objective Structured Clinical Examination] I guess. It placed definitely lots of stress on me from day one and now everyone in my group knows I am a very, very anxious person and very stressed person... There was a suggestion that I should go see a psychologist but I didn’t go... But I see that I need to see a psychologist because I just feel there is too much trauma, there is too much stress deep inside and I just feel like it is definitely affecting my life. It is affecting the way I deal with people, so I guess like most people I talk to immediately pick up that I am very hard on myself, that I am very stressed, and I am very anxious, and I worry that people would judge me... They say I have performance anxiety. – Participant 10 (International)
Remediation experience

The stigma associated with remediation and the way students were identified as needing extra attention was emphasised by the students in the following quotes:

So why would you tag me, I know that they are tagging students and telling consultants so they can help them but to be honest I didn’t feel like I was even helped by any of my consultants, they didn’t even offer to even sit with me to see how I communicate with patients or do different to support me so I just thought what is the point of embarrassing me and tagging me… I decided that I actually wanted nothing to do with the university. – Participant 10 (International)

I had so many interruptions. People just come and talk to me, I would walk away... They knew nothing about me. Students didn’t really talk to me [before requiring remediation], then they would come and talk to me [after experiencing academic difficulty], it was stigmatising. To be honest, I tried to be humble about the whole thing, a learning thing, avoid people that were like that. – Participant 7 (MAPAS – Pacific)

Tag not that helpful it doesn’t make sense, in my mind it doesn’t make sense as I didn’t get any extra support from the consultants. Difficult to have that conversation, did you know I’ve got a tag, what’s that mean, it’s confusing, oh I’m a really bad student from last year. So, it’s confusing, and it doesn’t feel reliably rolled out. – Participant 9 (MAPAS – Māori)

When it came to remediation practices, having an individual who was honest and cared about them and invested in their learning was beneficial. For example:

Wanting to teach you. Wanting to make you be a better doctor... I really like that, that they are passionate about teaching, they want you to get better, not kind of test you on how much you know before they teach you. – Participant 6 (MAPAS – Māori)

Figure 2: Themes relating to remediation.
Peer support from others in similar circumstances appeared to increase motivation and morale. In retrospect participants often reported the benefits of their time in remediation, including academic and clinical skill progression alongside personal development. Positive resiliency traits apart from reframing included exhibiting gratitude, positive attitudes, and improved coping mechanisms. Individualised coping strategies included peer support, outside hobbies and gaining perspective via religion/spirituality. Personal mentors were also said to be important:

There was something I did last year where I found out there was quite a big group of MAPAS students that had repeated where those that had already repeated talked to those who were repeating. I thought that was really good. – Participant 3 (MAPAS – Pacific)

Now I see a lot of lot of doctors we have been around, doctors, my supervisor, four or five, have mentioned they had to repeat years. That opened discussion a bit more, getting past that fear of failure. – Participant 4 (MAPAS – Māori)

MAPAS was highlighted as a positive support system shaping the students’ reflective and resilient response to academic hardship.

MAPAS has been very helpful, at times, I think there is nothing they can do, they are always open. – Participant 14 (MAPAS – Pacific)

Really grateful I had a lot of MAPAS tutorials, MAPAS help, older MAPAS students gave a lot of extra stuff support. [MAPAS] understand where you are coming from, for example when you say it’s just family, they know it’s not just for the night. They understand the customs and the traditions with it…they are great, they give out that house, they feed us, they have a separate study place for us, really nice. – Participant 13 (MAPAS – Pacific)

[MAPAS staff] helped me connect to one other person doing one special [remediation exam] that we were both doing. It meant we could sit down and study together, and it was nice to be around other people studying as well, it helps with motivation for each other... and because we were all discussing that how before we repeated, we saw people that had repeated, and we didn’t think of them any less. So, people are a lot harder on themselves. In the group setting we could all discuss that and see that we are not the only ones having a hard time. – Participant 2 (MAPAS – Māori)

The need for clearer communication on available support (unknown to this student) was apparent:

Well, tutorials would have been good, just to recap because it is very self-driven for specials [repeat test attempts] you just have to go over the recordings. I don’t know, even if it’s just an hour session each week to go over each topic, to ask questions, it would have been really helpful. – Participant 2 (MAPAS – Māori)

Communication breakdown was also linked to a loss of trust in the university as an institution:

The communication between staff, in terms of helping students supporting remediating, that needs to be a lot better than what it is now. These days I try not to get any support from the medical school because of my experience with them... because any form of support really would just be adding to their bias and prejudice against me. – Participant 1 (International)

Discussion

This study adds important insights into how at-risk MAPAS and international medical students experience academic difficulty within UoA, New Zealand. The main themes emerging from the student narrative of academic difficulty and remediation are the set and hidden curricula (including racialised environments) and complex social circumstances. The experience of remediation had both positive and negative aspects. While students expressed feelings of stigmatisation, they also noted the emergence of resilience and particularly valued MAPAS support.

The set curriculums high workload and unclear expectations were discussed by study participants. This study highlights the fact that despite the addi-
tional support offered to students requiring remediation it is not always communicated effectively, and there may be institutional factors contributing to negative student experiences and outcomes. At UoA, a “tag” is a way of identifying a student at academic risk (in order to support success), but once a student is identified as needing remedial work, there was stigma and perceived negative stereotyping associated with being identified in this way. In turn, this led to poor emotional and psychological health, which at the extreme, resulted in a disconnect and distrust of the institution. To ensure student trust in tertiary institutions, emotional and psychological wellbeing of students needs to be prioritised by destigmatising remedial labels and practices.

The hidden curriculum is a universal area of concern in medical training. The hidden curriculum, a punitive workplace culture resulting in student humiliation, negatively impacts student learning and mental health. This study supports the known association of poor mental health and student perceptions of discrimination and negative stereotyping. Also identified was the shame associated with accessing mental health treatment. Healthier management of the hidden curriculum is required globally, with the development of tools to better manage shortfalls within the current hidden curriculum under investigation.

Narratives of student experiences of prejudice and discrimination due to ethnicity, in the form of racism, were emphasised in this study. As defined by Jones, racism occurs on four levels: institutionalised racism (defined as differential access to the goods, services and opportunities of society due to one’s ethnicity); personally mediated racism that includes both prejudice (different beliefs about one’s abilities and motives due to ethnicity) and discrimination (differential treatment towards a person due to their ethnicity); internalised racism (where a person takes on society’s negative stereotypes and discrimination due to one’s ethnicity); and finally internalised racism (where a person takes on society’s negative stereotypes and discrimination due to one’s ethnicity) and discrimination (differential treatment towards a person due to their ethnicity).

Students displayed numerous life complexities and stressors within this study. The current literature supports this finding that student performance results from a complex interplay of factors. This includes external influences out of the students’ immediate control that affect academic outcomes such as life events and financial hardships. Another key factor in how students perform academically and cope with difficulties is their level of social connectedness with peers and parents. In this study, alongside social isolation, cultural differences led to acculturative stress, particularly within the international student cohort physically distanced from their support system. This acculturation and the resultant stress imposed on international students remains a collective challenge.

Remediation may be preventable for some at-risk students if identified early and supported effectively. Of benefit to the student experience was the pastoral support and mentoring—with evidence of student resilience post-remediation, particularly apparent in the MAPAS student group. A comprehensive framework of culturally appropriate support, as provided by MAPAS, may provide an exemplar for other tertiary institutions. Academic success for at-risk medical students requires a multi-faceted, inclusive, and culturally responsive approach delivered by diverse and self-aware staff. This study highlights the moral obligation to support international students to the level they require to succeed in medical programmes. Practically, this includes improved funding, resources, and representation for the international students within universities.

The limitations of this study include the heterogeneity of the cohort groups analysed (ie international and MAPAS students). Although there are commonalities in the perspectives and experiences related to academic difficulty and remediation of medical students of all backgrounds, we acknowledge that the experiences of international students and MAPAS students may differ significantly, making the combining of these student groups less ideal overall. Strengths of the study include a student-centred, in-depth analysis that builds upon previous quantitative work using mixed methods. The inclusion of the lead researcher who had insider status is seen as a positive contribution to the overall study as she was able to contextualise the experiences shared by the participants, which may have aided analysis.
**Conclusion**

This study has investigated the MAPAS and international medical student experience of academic difficulty and remediation at UoA. Navigating academic difficulty and remediation is a complex process for Indigenous Māori, Pacific and international medical students. Consideration of the impact of curriculum delivery, and improving student communication in a non-stigmatising way was highlighted by students. Exploring how to successfully identify, educate and eliminate the complexities of the hidden curriculum remains a barrier, especially racism during clinical training. Evidence of resilience within the study participants was apparent, especially within the MAPAS cohort. It remains important for culturally appropriate student support (especially for English as a second language students) to be provided. Universities have a moral obligation to ensure equity in access to and outcomes from medical training are available to all students.
COMPETING INTERESTS
Nil.

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URL

REFERENCES


## Appendix 1

### Introduction/hui process
- Mihimihi/Whakawhānaungatanga and offer prayer where appropriate
- Interviewer introduces themselves and explains the purpose of the meeting and format of the questions

### Background and context
Please tell me about your background and journey into the medical programme.
Prompts:
- High school attended
- Previous academic history and grade point average (GPA) on admission
- Previous degree or bridging course
- Year of the medical programme
- What is your living situation currently?
- What is your financial situation like currently?
- Where are your family and how is your relationship with them?
- Is spirituality or religion important to you and why?

### Academic difficulty
Please tell me about your experience with academic difficulty.
In what area(s) did you have academic difficulty?
Prompts:
- What are the factors that you believe lead you to have academic difficulty?
- In which ways did the programme curriculum contribute to your academic outcome?
- In which ways did the teaching and assessment contribute to your academic outcome?
- What helped or hindered you during the time you experienced academic difficulty (financial, study technique, work, family, geographical, access, academic background, medical issues, language or cultural barriers)?

### Remediation and support
What was your experience with remediation?
Prompts:
- What element required remediation?
- Specifically, how were you assisted during your remediation period?
- How did you access supports?
- What were your limiting factors (if unable to access supports)?

What supports did you access?
Prompts:
- What was your experience with the international student support/Māori and Pacific Admission Scheme team during your time being remediated?
- Pastoral care
- One-on-one mentoring
- Help with study techniques
- Time management
Remediation areas of improvement

• What are the strengths and limitations of the current remediation process?
• What would make the current remediation system better?

Thank you and koha

• Do you have anything else you would like to share?
• Would you like to sum-up your important points?
• Would you like a referral for any further supports?