BMJ Open is committed to open peer review. As part of this commitment we make the peer review history of every article we publish publicly available.

When an article is published we post the peer reviewers' comments and the authors' responses online. We also post the versions of the paper that were used during peer review. These are the versions that the peer review comments apply to.

The versions of the paper that follow are the versions that were submitted during the peer review process. They are not the versions of record or the final published versions. They should not be cited or distributed as the published version of this manuscript.

BMJ Open is an open access journal and the full, final, typeset and author-corrected version of record of the manuscript is available on our site with no access controls, subscription charges or pay-per-view fees (http://bmjopen.bmj.com).

If you have any questions on BMJ Open's open peer review process please email info.bmjopen@bmj.com

BMJ Open: first published as 10.1136/bmjopen-2023-082137 on 30 May 2024. Downloaded from http://bmjopen.bmj.com/ on June 8, 2025 at Agence Bibliographique de l Enseignement Superieur (ABES) .
Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.

BMJ Open

Exploring what GP registrars consider unique to consultations with Aboriginal and Torres Strait Islander patients: a mixed method study

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2023-082137
Article Type:	Original research
Date Submitted by the Author:	15-Nov-2023
Complete List of Authors:	Brumpton, Kay; Gold Coast Campus; James Cook University Woodall, Hannah; Rural Medical Education Australia; Gold Coast Campus Neill, Henry; James Cook University McArthur, Lawrie; University of Adelaide Ward, Raelene; University of Southern Queensland Evans, Rebecca; James Cook University, College of Medicine and Dentistry and Anton Breinl Research Centre for Health Systems Strengthening Sen Gupta, Tarun; James Cook Univ
Keywords:	Health Equity, MEDICAL EDUCATION & TRAINING, Primary Health Care

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

For peer review only

Enseignement Superieur (ABES) .
Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.

Exploring what GP registrars consider unique to consultations with Aboriginal and Torres Strait Islander patients: a mixed method study

Kay Brumpton[1,2,3*], Hannah Woodall[1,2,3], Rebecca Evans[3], Henry Neill[3], Tarun Sen Gupta[3], Lawrie McArthur[4], Raelene Ward[5]

[1] Griffith University, Gold Coast Campus, Southport, Australia

[2] Rural Medical Education Australia, Toowoomba, Australia

[3] James Cook University, Townsville, Australia

[4] The University of Adelaide, Adelaide, Australia

[5] University of Southern Queensland, Toowoomba, Australia

*Corresponding Author.

Kay Brumpton

190 Hume Street, East Toowoomba, QLD, 4350.

k.brumpton@griffith.edu.au

Abstract: 162 words

Total word count: 4322

Exploring what GP registrars consider unique to consultations with Aboriginal and Torres Strait Islander patients: a mixed method study

ABSTRACT

Objective: Understanding what general practice (GP) registrars consider as unique in their consultations with Aboriginal and Torres Strait Islander patients may help bridge the gap between patient-determined cultural safety and current practice. This project seeks to explore what GP registrars perceive as unique to their consultations with Aboriginal and Torres Strait Islander patients.

Design: This mixed methods study involved a survey considering demographic details of GP registrars, survey, and semi-structured interviews.

Setting: General practice training Australia

Participants: 26 registrars completed the survey. 16 registrars completed both the survey and the interview.

Results: Despite recognising a need to close the gap on health outcomes for Aboriginal and Torres Strait Islander peoples and wanting to do things differently, most registrars adopted a generic approach to all consultations.

Conclusion: This study shows limited alignment of GP registrars' perceived practicing behaviours and a community derived definition of cultural safety. Registrars appeared to approach consultations with Aboriginal and Torres Strait Islander patients similarly to all consultations.

Article summary:

Strengths and limitations:

-This is a small sample of GP registrars located in one Australian state and is based on self-assessment.

-The in-depth qualitative data collected provides good insight to this sample’s perceptions of cultural safety.

-The practicing behaviour of these registrars may be quite different and is worthy of further research.

Key words: Indigenous, cultural safety, general practice, registrars, consultations

Introduction

Patient-centred care is the recommended approach to general practice healthcare in Australia (1). Foundational to this approach is the patient-general practitioner (GP) partnership and acknowledgement of patient ideas, expectations, and values (2). Patient-centred care can help improve patient outcomes and is recognised as a key component of high-quality care (1).

Numerous models for structuring a patient-centred GP consultation are available to assist the GP to navigate a consultation effectively and efficiently (3). For example, many GPs will structure their consultation on the Calvary-Cambridge model (starting the consultation, gathering information, physical examination, explanation and education, and closure of the consultation) (4) whilst adding Neighbour's advice for preparing for the consultation and safety-netting (5), Pendleton's 'ICE' acronym (the patient's ideas, concerns, and expectations) (6), and Murtagh's safe diagnostic strategy and consideration of masquerades (7). However, these models are not specifically designed to address the particular health and cultural needs of diverse, disadvantaged or marginalised populations, such as Aboriginal and Torres Strait Islander peoples (1).

To address the deficit of models designed for culturally diverse populations, New Zealand have been adopting a framework for consultations that aims to provide a culturally safer consultation for Māori patients and their families (8). This Meihana Model of consultation considers connection between the patient and their support networks through physical, spiritual, and environmental wellbeing, consciousness and awareness, and wider support. Furthermore, it examines the impact of marginalisation, colonisation, racism and migration on the patient and consultation (8). The Meihana model is integrated with the Hui process (8). The Hui process is not dissimilar to the Calvary-Cambridge model (4) and involves initial greeting and engagement, making a connection and building relationships, attending to the agenda and closing the consultation. Within the Australian context, McKivett has proposed a clinical communication framework based on health equity and similar forces of patient-community, racism, colonisation, and marginalisation (9). The National

Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing uses Gee et. al.'s model of social and emotional wellbeing to provide a further structure for registrars to consider the historical, political and social determinants of health and the seven overlapping domains of body, mind and emotions, family and kinship, community, culture, country and spirituality and ancestors (10).

A safe general practice consultation requires both clinical and cultural safety (11). Identifying both culturally safe and unsafe care can be challenging, with both frequently being invisible to healthcare providers. Additionally, a lack of universal understanding of cultural safety has increased the challenge of identifying culturally safe care (12-14). To progress both patient care and the research agenda about cultural safety, the Australian Health Practitioner Agency (AHPRA) released a consensus statement defining cultural safety in 2019.

> *"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviors and power differentials in delivering safe, accessible and responsive healthcare free of racism"* (15).

In this study we aim to explore how GP registrars perceive that they conduct consultations with Aboriginal and Torres Strait Islander peoples. To facilitate this exploration, we have simplified cultural safety into the individual elements of the AHPRA definition. Often when teaching registrars how to conduct a general practice consultation, the consultation is deconstructed into its component parts (16). For example, the Calvary-Cambridge approach is a comprehensively deconstructed consultation model (starting the consultation, gathering information, physical examination, explanation and education, and closure of the consultation) (4). Similarly, when teaching cultural safety it may be useful to artificially consider the component parts of the AHPRA definition of cultural safety (determined by Aboriginal and Torres Strait Islander people, ongoing critical reflection, knowledge, skills, attitudes, practising behaviours, power differentials, safe, accessible and responsive healthcare, and racism free) (15).

1.2 Methods

Research design

A detailed description of the methodology has been published (17). This phase of the study involves a mixed method approach to understand what GP registrars consider as unique to consultations with Aboriginal and Torres Strait Islander patients.

Participants

All GP registrars undertaking active training in 2022 with [deidentified for review (DFR)] (the RTO) were invited to participate in the study. Registrars with this RTO work across DFR.

Data collection

Data collection techniques was in two parts. Part 1 involved a survey considering demographic details of the GP registrars and selected questions from West's cultural capability measurement tool (18) and Ryder's measurement of attitude change (19). This was followed by semi-structured interviews with GP registrars to explore their perception of consultations with Aboriginal and Torres Strait Islander patients. At the end of semi-structured interview, the interviewer requested participants rate on a 5-scale Likert score the importance of eye contact, silence, the use of traditional language, inclusion of spirituality in a consultation, and the importance of including family/elders in the consultation (17). A research assistant with no relationship to the registrars conducted the interviews.

Data analysis:

Survey data was descriptively analysed to both characterise the cases and provide contextual data for assisting in interpreting the interview data. Transcripts were studied using a content analysis approach using theory-driven codes derived from the AHPRA definition of cultural safety and emerging data-driven codes (15, 20).

Reflexivity:

The principal investigator Author (A) 1 is an experienced GP academic working in an Aboriginal Medical Service. A2 is a senior researcher, A3 an Aboriginal cultural educator for the RTO, A4 a clinician researcher, A5 and A6 are clinical academics, and the latter is director of the RTO. A7 is an Aboriginal academic from DFR Nations. The research assistant is an evaluation coordinator with the RTO and conducted registrar interviews. A community advisory group of Indigenous Australians have been involved in the research since inception.

Results

Participant characteristics

A total of 26 registrars responded to the recruitment email and completed the survey. Of these, 16 registrars also completed an interview. All 26 survey respondents agreed to be interviewed, but practicalities of interview organisation resulted in only 16 registrars being interviewed. Most registrars were less than 34 years old, had graduated from an Australian university and had limited experience in Aboriginal and Torres Strait Islander health. Two registrars self-identified as Aboriginal and Torres Strait Islander.

A total of 618 minutes of audio-recording was analysed. The median length of interviews was 33.4 minutes with the longest interview 95 minutes and the shortest 18 minutes.

Registrars described the structure of the consultation, how they perceived they demonstrated cultural safety, and their attitude towards Aboriginal and Torres Strait Islander peoples.

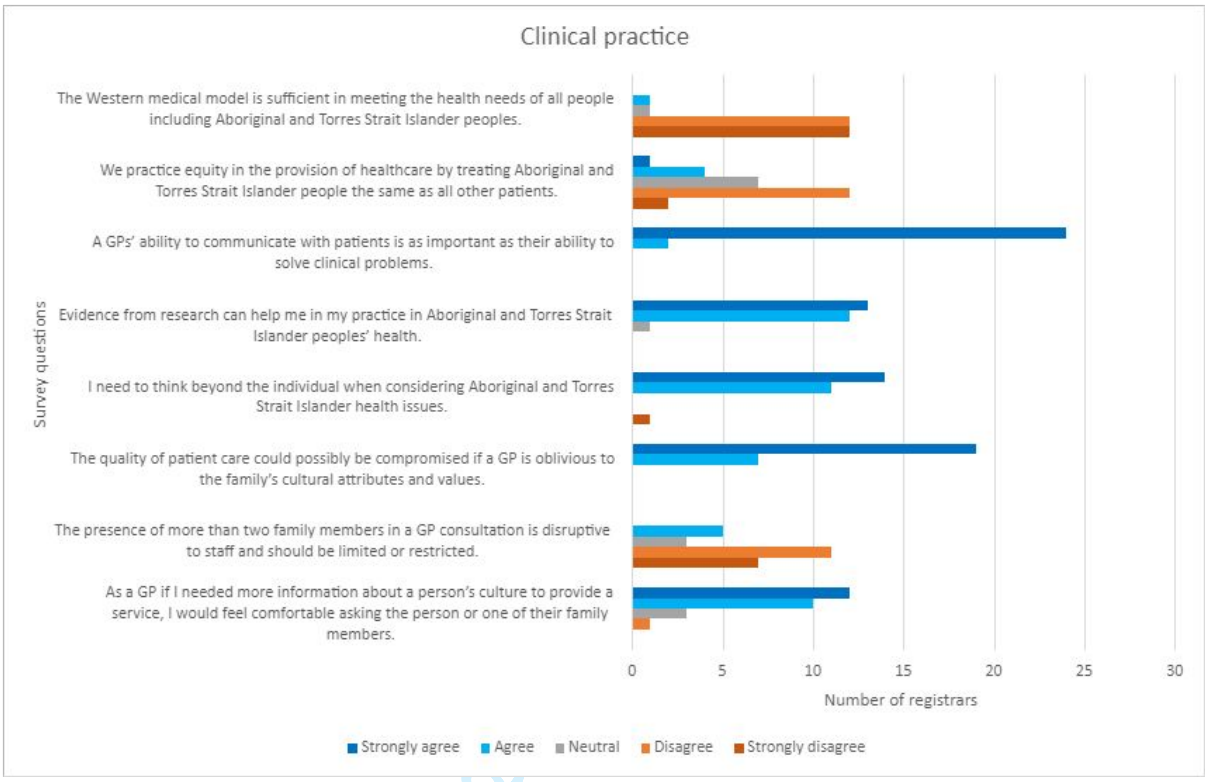
Structure of the consultation

Registrars described models of care aligned with patient-centred care and emphasised holistic care and continuity of care.

> I think what working in Aboriginal and Torres Strait Islander health has taught me as well is that to appreciate the person within the context of them, their family and their community and their culture. And I think the fact that I'm open to that makes it a little bit easier for Aboriginal and Torres Strait Islander people to come to me. (1131)

Registrars provided limited examples of how knowledge of a patient's Aboriginal and Torres Strait Islander identity and/or Aboriginal and Torres Strait Islander history changed clinical practice. Most registrars considered that a Western medical model of health care did not meet the needs of patients. However nearly half of the registrars indicated they would not treat Aboriginal and Torres Strait Islander patients differently to other patients (Graph 1).

Graph 1: Registrar survey responses



Most registrars reported in the interviews a similar consultation approach for all patients, apart from additional health promotion and screening.

> I usually do very much the same thing as I do with other people. But I think in terms of certain things, as in screening or other things that are slightly different for Aboriginal population versus the non-Aboriginal population, I kind of just do a blanket statement and say, "This is because of your background that you identify yourself as [Aboriginal and Torres Strait Islander] there will be this and this, this, this, that needs to be done just for your health sake…I do offer them health assessments and stuff like that…So I think that's something different because you're eligible for those things. But I don't really treat them any different really. I see them as the same. (6434)

One registrar had a very narrow application of cultural safety describing it as a discrete component of the consultation and that cultural safety was determined within the first stages of a consultation.

> And that the cultural safety stuff is actually almost like a barrier that you need to get over. And once you get that out of the way the interaction in the consult becomes like any other interaction and consult with any other patient... (6389)

Demonstration of cultural safety

Registrars perceived they were delivering culturally safe care through focussing on communication skills with Aboriginal and Torres Strait Islander patients and considered communication skills as important as clinical skills (Graph 1).

1.Non-verbal communication such as listening, body position/stance, eye contact and physical touch. Overall silence in a consultation was considered important (average 3.875/5), but not unique to consultations with Aboriginal and Torres Strait Islander patients.

Registrars were divided in the importance of eye contact and variably described approaches to determining the appropriateness of eye contact for individual patients.

> I actually found that touch was actually a good thing: sitting there and like actually holding their hand (6389).

> …if I have a patient who I've seen from the chart is Indigenous, I normally start off avoiding eye contact initially and then just kind of see what they're doing to then see, is this person also doing it [avoiding eye contact]? And then try and feel out early on. Does it seem like they're looking away or uncomfortable? Or if I look them in the eyes do they appreciate that

> and prefer that?” (4091)

2. Verbal communication skills included use of informal language (including slang and humour), avoiding jargon, mirroring a patient’s speech, and a conversational or yarning approach.

> I guess the biggest thing I try to do is not create like a authority type situation where I am above them by any means. Just because I'm a doctor, I try to be as casual as I can. I want them to treat me like somebody ...that they're just talking to casually and that they would want to just tell everything to...So, I guess appropriate understanding, common slang terms and then appropriate words to use in return... So, things like when they say that, oh, “This is deadly”. (2601)

3. To build rapport with patients, registrars described enquiring about connection to country and/or family. Registrars appeared to assume this was a safe question even when patients described loss of connection to family and country.

> One thing I learned after our training as well actually is that often when we've got some time, especially after doing our consult, it is just to ask a little bit about, you know, where are you from and like how long have you been there? Is that is that where your family is from or just try to get a bit more of an understanding? I have found that when I've asked those questions, I found out a lot of surprising things... (2601)

Registrars described use of the question, “Are you of Aboriginal or Torres Strait Islander origin?” as both a barrier and facilitator to creating rapport with patients. Some registrars were concerned this question could be culturally unsafe and racist. Other registrars assumed the question was safe or facilitated patient safety.

I know there's one time where it was a new patient to me and I was just filling up the system for the patient's profile. And I think rather than saying, "Do you identify yourself as?", you know, in a more politically correct way, I kind of just said, oh, "Are you Aboriginal?" And then they're like, “Yeah, well, I can be, can't I?” And I was like, “Oh, no, I didn't mean like that, you know?” Yeah. So, I think it just slipped too quickly versus me processing it and using it the more PC [politically correct] way of asking. Yeah. So, I had to quickly say to them, “No, no, no, I didn't mean that. I just meant I just need to fill up your information. Doesn’t matter who you identify, what you identify as, it’s just with the Aboriginal status, you do get a lot more perks or a lot more things that we need to look into. (6434)

But on the flip side, I'm blatantly asking, "Are you a particular race?", so that I could treat you accordingly. So, I'm very conflicted with that sometimes. Or a young child that comes in asking them like, have you had those extra vaccines because you're at risk of this and this. So, it's so, I, I try to say I'm trying to be professional, but I can see how some people can see that as offensive. It's like, "Oh, how dare you ask me that, so I'm lesser so I need more vaccines or need..?" (3270)

Try not to be afraid of asking their identity. Do you identify yourself with Aboriginal or Torres Strait Islander and check with them and let them know this practice welcomes all patients we don't discriminate because you are Indigenous population and also can help them if they do feel something they don't understand or if they do feel they get confused, or if they do feel a bit unsafe, make sure they let us know. (7358)

Registrars grappled differently with the concept that identification as an Aboriginal and Torres Strait Islander person may be fluid.

> ...being mindful that to always ask if someone identifies as Indigenous or Torres Strait Islander because obviously looks can be deceiving and we can't always assume. And sometimes I find that here maybe one parent identifies as Indigenous, but they want to wait a little bit for the child to grow up a little bit older, for them to identify or to make a decision if the child will identify as Indigenous or Torres Strait Islander but.. So being mindful that that can, I've seen that change. (6278)

> I don't tend to ask [about identity] and that's because it's already collected. So, I already know from the information. If it's not written there, it often comes up though, if I'm having to do additional paperwork, then I say, "I just I would like to check. Do you identify as Aboriginal or Torres Strait Islander?"...And, so, I often don't necessarily ask them, particularly in the consult every time. (7400)

4. Registrars were sometimes aware of power differentials and attempted to address this by using language that mirrored patient language, wore casual clothing, and adopted a body posture that did not create a physical height gradient.

> ...in the hospital ED setting but I try and sit down if I can. If they're on a bed or if we're in a consult room, sit down. So there isn't...[a feeling] I'm standing over them... And a lot of body language issues like not being necessarily front on it can be kind of confrontational in the same way as the eye contact sitting rather than standing over them. (4091)

Registrars minimised potential power differentials by expressing the similarities they have with Aboriginal and Torres Strait Islander patients. For example, similar family structures, darker skinned or also identifying as Aboriginal and Torres Strait Islander.

> So that could be something culturally as well. When I have spoken to them, we also have a very strong cultural framework in which the families are very united. We also call our elders, uncle and aunties, and they also call everyone uncle and aunties. So when I have discussed, they have found that this is more closer to what their culture is. (1111)

5. Several registrars described creating a safe welcoming environment for Aboriginal and Torres Strait Islander patients through displaying Aboriginal flags, maps, artwork, acknowledgements to country and employment of Aboriginal and Torres Strait Islander staff within the practice. An Aboriginal and Torres Strait Islander registrar spoke of the physical environment being less important in the delivery of culturally safe care (9304).

> I don't work in a practice where there's Aboriginal posters everywhere. I work in a practice where it's not very welcoming at all and that's something that I will change. But the aesthetics are secondary to actually being open and honest in your communication and accepting people for who they are on their journey and helping them to progress their health journey in a way that it's just enough for them. (9304)

6. Flexible and longer appointment times were seen as an important way of improving access to care.

> If I have a white patient rambling, I cut him off all the time. I try and give more time [to Aboriginal and Torres Strait Islander patients] and make sure that some rapport can be built. (4091)

7.About one third of registrars indicated that the presence of two or more family members in a consultation is disruptive and should be limited or restricted (Graph 1). However, in interviews registrars recognised the importance of family within consultations.

> I always offer for a family member to be present because I think as much as support as I can give, often times family members to provide way more emotional support. (6278)

All registrars agreed (n=6) or strongly agreed (n=19) that the quality of patient care could be compromised if a GP was oblivious to the family's cultural attributes and values.

8. Registrars had divergent views on the importance of being considerate of spirituality in a consultation. An Aboriginal and Torres Strait Islander spoke of spirituality as part of providing holistic care.

> Spirituality isn't something I would identify with Aboriginal culture so much (7216).

> I think it's very important because that's part of their I guess their identity and the medical perspective is also important to consider. Like, not like we always talk in med school spirituality doesn't mean psychosis and hallucinations (6278).

> It [spirituality] underpins attitudes to health, attitudes to healing and health for Aboriginal people is a holistic thing. It's not just I hurt my toe, or I've got a chest pain, it's got to do with everything else that's going on in their life. And that includes spirituality. (9304)

9 .Other factors registrars considered important in demonstrating cultural safety included the provision of culturally tailored patient education, culturally appropriate referrals, patient consent, confidentiality, and privacy.

> But privacy is really number one….And I actually found in a way, in a weird way, not having an Indigenous background sometimes made them prefer me as opposed to go there because there was the workers who were the aunties or the cousins or the all in the community and they were they didn't want word getting out about certain things.” (6389)

Attitude

Registrars described a variety of attitudes that they considered to be important in consultations with Aboriginal and Torres Strait Islander patients, particularly being non-judgemental, open-minded, kind, and respectful.

> I don't think patients expect us to be culturally aware of everything and every possible culture. But I think as long as we're willing to learn, I think patients appreciate that. And I think if you're being honest with patients like ‘please feel free to correct me if I'm wrong about your culture or if you feel like I'm saying anything offensive.’ I would be happy to correct my words, and I think people would appreciate that. If you're just being honest, if you don't know, then you don't know. (6278)

> I think the biggest tips and tricks I would say is I guess the simple golden rule is to treat everyone like you want to be treated. (2797)

Registrars thought they were demonstrating respect when acknowledging a person’s Indigenous status, being considerate of local customs, providing patient-centred care, referral to culturally appropriate services, treating Aboriginal and Torres Strait Islander patients the same as other patients, and having an open-minded and non-judgemental attitude.

Registrars described their Aboriginal and Torres Strait Islander patients in a variety of ways.

Registrars frequently referred to Aboriginal and Torres Strait Islander patients as being like themselves or not different to other patients. Many of the descriptors "othered" Aboriginal and Torres Strait Islander people and were from a deficit perspective. Negative descriptors of Aboriginal and Torres Strait Islander patients were commonly used including disadvantage, dysfunction, chronic disease sufferers, substance abusers, non-compliant, swearing and low levels of literacy. Positive descriptors were around attitude and personality (genuine, kind, humorous, honest, polite, understanding, trusting, forgiving, patient). Some registrars described the diversity of their patients and how some Aboriginal and Torres Strait Islander patients are higher income earners than medical professionals. Other registrars described differences such as family structures.

> Aboriginal Australians come...They're not just one homogenous group, there are all kinds of different people with all kinds of different life experiences, family experiences and cultural norms, which makes it such a diverse group to work with, I find. (4091)

Registrars regularly referred to Aboriginal and Torres Strait patients "as human" or "like a human".

> I think, treating them like a human being. That's a big thing. I think that no two patients will be the same regardless of their background. And only I guess, only if you absolutely have to ask, you know, about certain things in their history, then then you can bring up the subject. But the biggest thing is that they're not a number. They're a person just like every other person in the world. (3270)

> I mean, treating them as human. Yeah, I think it's awareness of those communication issues or different communication norms, awareness of history and how that could impact and shape the consult. Letting them run it, making sure I try and avoid as much paternalism as possible. I try and do that for all my patients, not just Aboriginal Australian ones. (4091)

> I think just be respectful and treat them the same as you would when you're treating non-Aboriginals or family or family friends like you don't treat them any different really, because they're also humans. (6434)

Discussion

Despite recognising a need to close the gap on health outcomes for Aboriginal and Torres Strait Islander peoples and wanting to do things differently, most registrars adopted a generic approach to all consultations. Registrars did not explicitly mention patient-centred care or name any formal models of consultation approaches. When considering the components of the Meihana and Hui model (8), and McKivett framework (9), some registrars touched on elements. Most registrars described initiating the consultation in a similar format for all consultations. Engagement and rapport were variably approached with some registrars asking about connection to country and family. Identifying patients as Aboriginal and Torres Strait Islander was challenging for some. Previous studies identified similar barriers to GPs asking patients about their identity (21). Although we did not directly ask about confidence, many registrars in this study did not appear confident asking about identity. This is compared to 74.5% of registrars in a previous study (22). Apart from consideration of the epidemiology of disease, attention to the clinical purpose of the session was like all consults. Registrars did not appear to have a structured approach to considering elements of wellbeing such as connection to community, family and kinship, mind and emotions, spirituality and body (10).

Registrars focussed on communication skills as a major way of demonstrating cultural safety. Registrars frequently spoke about simplifying speech for patients, trying to use similar speech patterns, and questioning patients if they understood. Despite many registrars describing a conversational approach to a consultation, registrars frequently used language such as “talking to them”, and “where I can express myself”.

Appropriate eye contact with patients was clearly a concern for registrars with several describing an “eye-dance” when trying to gauge from social cues if the patient was comfortable with eye-contact. Registrars also reflected on how eye contact, or lack of eye contact, made them feel: rather than how the patient felt. One registrar mentioned physical touch as part of culturally safe care, reflecting “it was a good thing” again without considering how the patient felt about this caress.

A non-judgemental, open-minded, respectful, and kind attitude was considered to be culturally safe. However, many of the descriptions of Aboriginal and Torres Strait Islander patients were racist, and not identified as such by the registrars. The use of metaphor and simile to state “treating them like/as a human” highlights the transformative unlearning that needs to occur. Similarly, describing initiatives to achieve health equity as “perks” further marginalises the disadvantaged. A few registrars described treating Aboriginal and Torres Strait Islander patients using the moral rule of “treat others the way you want to be treated”. This again fails to recognise that cultural safety should be determined by those being treated, that is, “treat others the way they want to be treated”. Other registrars were concerned about how not to be racist in asking patients to identify their ethnicity or applying an epidemiological approach to the consultation. Racism, and lack of recognition that fair-skinned people may identify as Aboriginal and Torres Strait Islander, was also demonstrated by a registrar who described a culturally unsafe approach to consultations by interrupting “white people” when they are taking a narrative or yarning approach within the consultation. Other registrars assumed that because the patient appeared to be Caucasian and/or of higher socio-economic status that they would not be affected by colonial failings.

Conclusion

This study shows amongst this small sample there is limited alignment of GP registrars’ perceived practicing behaviours and the definition of cultural safety with that proposed by AHPRA.

Furthermore, registrars appeared to approach consultations with Aboriginal and Torres Strait Islander patients similarly to all consultations. No models of consultations were described but described practice was aligned with a generic approach based upon holistic patient-centred care principles. Given the considered importance of a culturally safe consultation, it is important for us to understand what the key distinguishing elements of a culturally safe consultation are and further research is required.

Declarations

Ethics approval and consent to participate:

The James Cook University Human Research Ethics Committee approved this study (H8296) following review by Aboriginal and Torres Strait Ethics Advisors in accordance with the National Health and Medical Research Council guidelines.

Consent for publication: Not applicable

Patient and Public Involvement: Expert community panel involved from inception of the research project including development of the research questions and design of the study.

Availability of data and materials: The datasets analysed during the current study are not publicly available due to participants being potentially identifiable from the small dataset but are available from the corresponding author on reasonable request.

Competing interests: Nil

Funding: This work was supported by the Australian College of Rural and Remote Medicine Education Research Grant.

Authors' contributions:

KB conceptualized and designed the project, analysed, and interpreted the patient data, and was the major contributor in writing the manuscript.

HW, RE, HN, TSG, LM and RW contributed to refining the project, data analysis and drafting and revision of the manuscript.

Acknowledgements: Kerrilee Gow managed the project and undertook data collection.

References

1. Australian Commission on Safety and Quality in Health Care. Patient-centred care: Improving quality and safety through partnerships with patients and consumers. Sydney: 2011. p. 104. https://www.racp.edu.au/docs/default-source/about/consumer-advisory-group/racp-framework-for-improving-patient-centred-care-and-consumer-engagement.pdf

2. Delaney L. Patient-centred care as a approach to improving health care in Australia. Collegian. 2018;25:119-23.

3. Morgan S, Chan M, Starling C. Starting off in general practice - consultation skill tips for new GP registrars. AFP. 2014;43(9):645-8.

4. Silverman J, Kurtz S, Draper J. Skills for Communicating with Patients. Radcliffe Medical Press (Oxford). 1998.

5. Neighbour R. The inner consultation: how to develop an effective and intuitive consulting style. 2nd ed. Oxford: Radcliffe Medical Press; 2004.

6. Pendelton D, Schofield T, Havelock P. The consultation: an approach to teaching and learning. Oxford: Oxford University Press; 1984.

7. Murtagh J, Rosenblatt J, Murtagh C, Coleman J. Murtagh general practice. 8th ed. Australia: McGraw Hill; 2021.

8. Pitama S, Bennett S, Waitoki W, Haitana T, Valentine H, Pahina J, et al. A proposed Hauora Māori clinical guide for psychologists: using the Hui Process and Meihana Model in clinical assessment and formulation. New Zeal J Psychol. 2017;46(3):7-19.

9. McKivett A, Paul D, Hudson N. Healing conversations: developing a practical framework for clinical communication between Aboriginal communities and healthcare practitioners. J Immigr Minor Health. 2019;21(3):596-605.

10. Gee G, Dudgeon P, Schultz C, Hart A, Kelly K. Social and emotional wellbeing and mental health: an Aboriginal perspective. In: Dudgeon P, Milroy M, R W, editors. National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emitonal wellbeing 2017-2023. Revised ed. Canberra: Department of Prime Minister and Cabinet: Commonwealth of Australia; 2017. p. 55.

11. Ahpra & National Boards. The National Scheme's Aboriginal and Torres Strait Islander health and cultural safety strategy 2020-2025. Canberra: Ahpra and National Boards; 2020.

12. Grant J, Parry Y, Guerin P. An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. Aust N Z J Public Health. 2013;37(3):250-6.

13. Paul D, Hill S, Ewen S. Revealing the (in)competency of "cultural competency" in medical education. AlterNative. 2012;8(3):318-328.

14. Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee. Cultural Respect Framework 2016-2026. Adelaide: Australian Health Ministers' Advisory Council; 2016.

15. AHPRA & National Boards. A consistent baseline definition of cultural safety for the National Scheme. Canberra. 2019.

16. Roth R, Willems J. A new framework for teaching the art of general practice consultation to registrars and supervised doctors. Australian Journal for General Practitioners. 2022;51:310-5.

17. Brumpton K, Ward R, Evans R, Neill H, Woodall H, McArthur L, et al. Assessing cultural safety in general practice consultations for Indigenous patients: protocol for a mixed methods sequential embedded design study. BMC Medical Education. 2023;23(1):306.

18. West R, Wrigley S, Mills K, Taylor K, Rowland D, Creedy D. Development of a First Peoples-led cultural capability measurement tool: a pilot study with midwifery students. Women Birth. 2017;30(3):236-44.

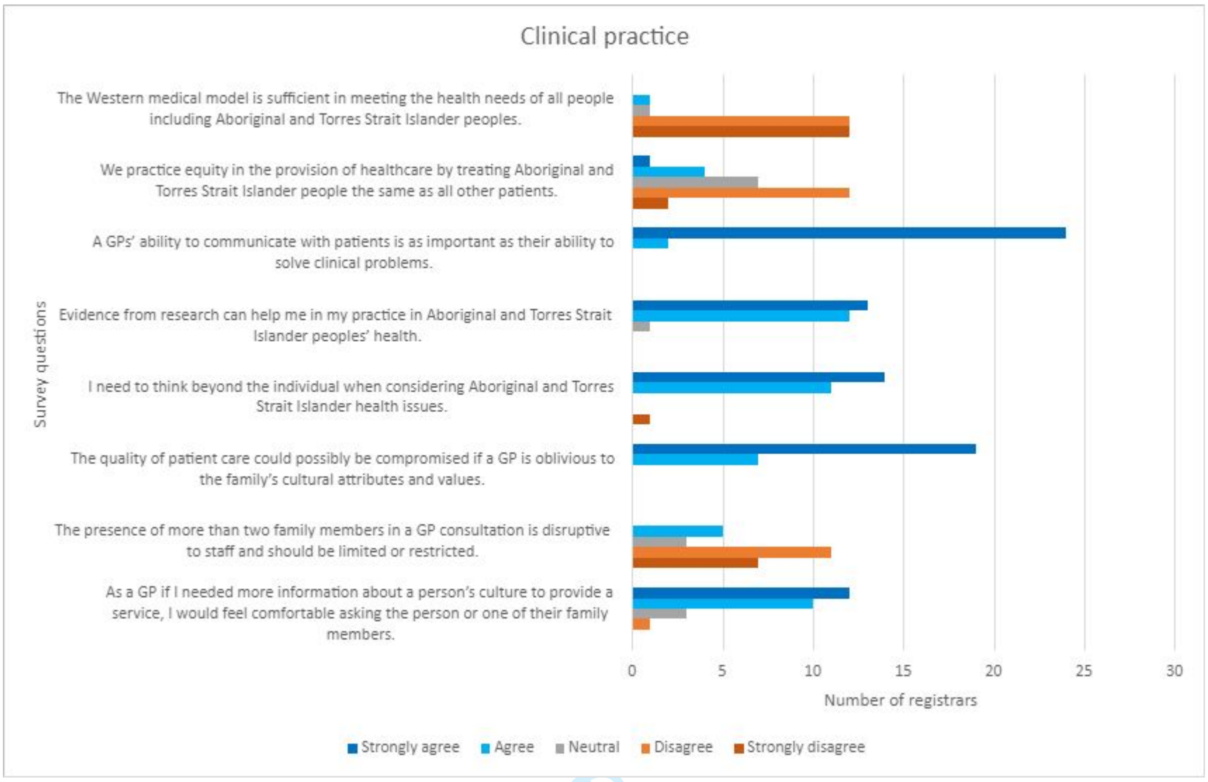
19. Ryder C, MacKean T, Ullah S, Burton H, Halls H, McDermott D, et al. Development and Validation of a Questionnaire to Measure Attitude change in Health Professionals after Completion of an Aboriginal Health and Cultural Safety Training Programme. Australian Journal of Indigenous Education. 2019;48(1):24-38.

20. Erlingsson C, Brysiewicz P. A hands-on guide to doing content analysis. African Journal of Emergency Medicine. 2017;7(3):93-9.

21. Kelaher M, Parry A, Day S, Anderson I, Paradies Y, Parkhill A. Improving the identification of Aboriginal and Torres Strait Islander people in mainstream general practice. In: The Lowitja Institute, editor. Melbourne. 2020.

22. Morgan S, Thomson A, O'Mara P, Tapley A, Henderson K, van Driel M, et al. Identification of Aboriginal and Torres Strait Islander status by general practice registrars: Confidence and associations. Australian Family Physician. 2016;45(9):677-82.

Graph 1 – Registrar survey responses



Brumpton *et al. BMC Medical Education* *(2023) 23:306*
https://doi.org/10.1186/s12909-023-04249-6

BMC Medical Education

STUDY PROTOCOL **Open Access**

Assessing cultural safety in general practice consultations for Indigenous patients: protocol for a mixed methods sequential embedded design study

Kay Brumpton[1*], Raelene Ward[2], Rebecca Evans[3], Henry Neill[3], Hannah Woodall[1], Lawrie McArthur[3] and Tarun Sen Gupta[3]

Abstract

Background Assessment of cultural safety in general practice consultations for Indigenous patients is a complex notion. Design and development of any assessment tool needs to be cognizant that cultural safety is determined by Indigenous peoples and incorporates defined components of cultural safety and current educational theory. Consideration of how social, historical, and political determinants of health and well-being impact upon the cultural safety of a consultation is also important. Given this complexity, we assume that no single method of assessment will be adequate to determine if general practice (GP) registrars are demonstrating or delivering culturally safe care. As such, we propose that development and assessment of cultural safety can be conceptualised using a model that considers these variables. From this, we aim to develop a tool to assess whether GP registrars are conducting a culturally safe consultation, where cultural safety is determined by Aboriginal and Torres Strait Islander peoples.

Methods This protocol will be situated in a pragmatic philosophical position to explore cultural safety primarily from the Australian Aboriginal and Torres Strait Islander patients' perspective with triangulation and validation of findings with the GP and GP registrar perspective, the Aboriginal and Torres Strait Islander community, and the medical education community. The study will integrate both quantitative and qualitative data through three sequential phases. Data collection will be through survey, semi-structured interviews, an adapted nominal group technique, and a Delphi questionnaire. We aim to recruit approximately 40 patient and 20 GP participants for interviews, conduct one to five nominal groups (seven to 35 participants) and recruit fifteen participants for the Delphi process. Data will be analysed through a content analysis approach to identify components of an assessment of cultural safety for GP registrars.

Discussion This study will be one of the first to explore how cultural safety, as determined by Indigenous peoples, can be assessed in general practice consultations. This protocol is shared to stimulate awareness and discussion around this significant issue and prompt other studies in this area.

Keywords Cultural safety, General practice, Registrars, Indigenous, Assessment

---

*Correspondence:
Kay Brumpton
k.brumpton@ruralmeded.org.au
Full list of author information is available at the end of the article

Background

Much has been written about the concept of cultural safety and its importance in the improvement of health care delivery for racial minority groups, particularly for Indigenous peoples affected by colonisation [1, 2]. Ramsden, a Māori nurse, who first proposed the concept of cultural safety in healthcare, articulated a three-step progression in the development of cultural safety from cultural awareness to sensitivity, and safety [3]. More recently, development of cultural safety has been described as a continuous circular model from awareness (cognizant of differences) to sensitivity (understanding and respecting these differences), competence (responding to own bias and developing skills), and safety [4]. Others, including Paul et al. [5], argue however that any discussion on cultural safety that focuses on differences and disparity between cultures, rather than reflection on practice, should be challenged.

Indeed, cultural safety is a complex notion and lack of a consistent definition has somewhat stymied the progression of evidence in this space [6]. Currently, whilst the concept of cultural safety or similar [7, 8] is embedded deeply in health and health education policy and frameworks [9–13] there is minimal evidence for the effectiveness of cultural safety training in improving patient health outcomes [14–18]. The use of a consistent definition for cultural safety provides an opportunity to provide clarity around the terminology used and address the paucity of evidence related to cultural safety [14–18]. Australia has attempted to address this by releasing a consensus statement, agreed upon by the Australian Health Practitioner Regulation Agency (AHPRA), regarding Australia's colonised Indigenous population of Aboriginal and Torres Strait Islander peoples [19]:

> *"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Cuturally safe practise is ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism" [19].*

According to the Australian Bureau of Statistics, Australian Aboriginal and Torres Strait Islander people represent approximately 3.2 percent of the Australian population [20] and have a burden of disease 2.3 times that of non-Indigenous Australians [21]. Aboriginal and Torres Strait Islander peoples' strength and resilience, as one of the oldest world cultures, is impacted by the colonisation of Australia. Colonisation is described by Aboriginal health academic McKivett as: "the colliding of two worlds and the meeting of different systems of knowledges and beliefs" [8] p596. Colonisation, along with social determinants of health, continue to affect the health and wellbeing of Aboriginal and Torres Strait Islander peoples today. As such, Aboriginal and Torres Strait Islander people, again as described by McKivett et al., "Are striving to maintain collective values, traditions and beliefs whilst also coping with high burdens of chronic disease, reduced life expectancies and the impacts of grief, loss and trauma" (p596).

In Australia, AHPRA worked with other significant stakeholders to develop a national Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy (2020–2025) which casts a vision that patient safety, including both clinical and cultural safety, is the expected standard of care for Aboriginal and Torres Strait Islander peoples and that this standard of safety is defined by Aboriginal and Torres Strait Islander peoples [22]. The National Strategy also considers that developing a culturally safe general practice workforce is a key strategy in improving health outcomes for Aboriginal and Torres Strait Islander peoples [22]. Delivery of culturally safe health care can improve quality of health care [23] and should, by inference, improve disparities in the life expectancy and morbidity patterns experienced by Indigenous peoples [24, 25]. For most patients in the developed world, a General Practitioner (GP) is the first point of contact when accessing healthcare and is the most persistent relationship for a patient within the health system [26]. As such, a culturally safe GP can play a crucial role to closing the gap in health outcomes for Indigenous peoples [27]. We argue that development of cultural safety in GP registrars is a priority for general practice training [28]. Logically, the development of cultural safety should occur early in postgraduate training as reflected by the recent inclusion of the AHPRA definition of cultural safety into the Australian GP curricula by the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) [29, 30]. The AHPRA consensus statement, along with recent educational developments (for example, revision of Australian Medical Council graduate outcomes [31], and assessment changes by the RACGP [28]), provides opportunity to reassess the health professional educational response to teaching and assessment of cultural safety.

Understanding how GPs and GP registrars define, develop, and perceive cultural safety could assist identification of areas where cultural safety is lacking or needs improvement. A 2016 integrative review, conducted prior to release of the AHPRA definition, demonstrated a significant gap in evidence on how cultural safety is developed by GPs when consulting with Aboriginal and Torres Strait Islander peoples [32]. The literature cited suggests a lack of understanding regarding cultural safety development in GP registrars, or how cultural safety training influences GP registrar behaviour and consulting practices. Furthermore, as assessment is considered to drive learning, consideration of how cultural safety can be assessed, in a formative and summative manner, is required. These assessments require a clear definition and description of culturally safe practice, which must be determined by Aboriginal and Torres Islander people and communities themselves. We are not aware of any assessment tools of consultation skills based on community-derived definitions.

Given the complexity of cultural safety, we assume that no single method of assessment will be adequate to determine where health professional learners sit on a spectrum from racist, through to demonstrating culturally safe care. Similarly, we assume that no single model of assessment or educational theory will incorporate this intricacy. As such, we propose that development and assessment of cultural safety can be conceptualised using a model that considers and, to some extent, aligns with: Miller's pyramid (a commonly used framework for the assessment of clinical skills/performance/competence) [33], the AHPRA definition of cultural safety [19], the continuum of cultural safety [3, 4], Aboriginal ways of knowing, doing, and being [34], transformative learning theory [35], and Gee et al.'s model of social and emotional wellbeing that incorporates historical, social and political determinants of health and wellbeing [26] (Fig. 1).

To explain this model further we start with Miller's pyramid (the blue triangle in Fig. 1). We use the example of training for an Australian GP fellowship. General practice training in Australia can currently be undertaken through one of five different pathways including the Australian General Practice Training (AGPT) program, Remote Vocational Training Scheme, Rural Generalist, Independent pathway and the General Practice Experience Pathway [36]. Fellowship can be achieved through two colleges, RACGP or ACRRM. RACGP registrars typically train for two to three years in general practice before completing a series of exams, including two written papers – "knows and knows how" and a clinical competency exam – "shows"—where at least one out of nine stations relate to an Australian Aboriginal and Torres Strait Islander patient with the same marking rubric used for all cases in the exam. RACGP registrars are currently not assessed summatively in the workplace in performance integrated practice ("does") [37]. In contrast, ACRRM registrars normally complete an additional training year when compared to RACGP registrars [38]. Their assessment includes direct observation of consultations "does" (referred to as mini-CEX) and multi-source feedback (MSF). A registrar is not required to include Australian Aboriginal and Torres Strait Islander patients in this process [38]. Summatively, a Structured Assessment using Multiple Patient Scenarios (best described as a hybrid viva-voce and objective structured clinical examination) is used and will typically involve at least one scenario with the candidate doing outreach clinics to a remote Australian Aboriginal community [38]. These assessments have not been validated with Australian Aboriginal and Torres Strait Islander patients [39, 40]. Recent authors have also proposed an additional layer to Miller's pyramid labelled "is", reflecting the concept of professional identity formation [41] and in the case of cultural safety, encapsulating ongoing critical reflection. In addition, we propose a further layer at the base of Miller's pyramid to reflect cultural incapacity or unconscious incompetence [42] as some health professional learners are not aware of their culturally unsafe stance.

Furthermore, using Miller's pyramid also allows us to demonstrate where terminology regarding cultural safety, or similar, align and ideally minimise confusion (orange triangle in Fig. 1). For example, cultural safety is the "is" and "doing" of Miller's pyramid whilst cultural competency is the "showing how". We also invert the pyramid for cultural safety terminology reflecting that we are wanting to place greater value on work-based assessment of cultural safety rather than static knowledge.

Additionally, within the model we overlay a triangle with the Australian AHPRA definition (the yellow triangle in Fig. 1). Within this framework the assessment of cultural safety should be considerate of the complex interplay between health professional learners and the components of the AHPRA definition [19]. The model also illustrates the importance of development and assessment of cultural safety being embedded in Aboriginal ways (the red triangles in Fig. 1). As such, Miller's pyramid, the AHPRA components of cultural safety, and the continuum of cultural safety are encapsulated within Martin and Mirraboopa's theoretical framework of Aboriginal ways of knowing (knowledge of history, culture, customs and beliefs), doing (skills and practicing behaviours) and being (critical reflection) [34].

Next, we nominate these components are founded upon a transformative learning ethos where the educational and assessment model aims, as described by Frenk et al. [35], to produce transformative leaders who are "enlightened change agents" (p 1952). Finally, the whole model is dependent on cultural safety being determined by Indigenous peoples and must consider the complexities of health and wellbeing including social, historical, and political determinants of these.

Our model provides a framework to both demonstrate and explore the complexity of cultural safety within a general practice consultation. The AHPRA consensus statement, is very broad, and whilst describing cultural

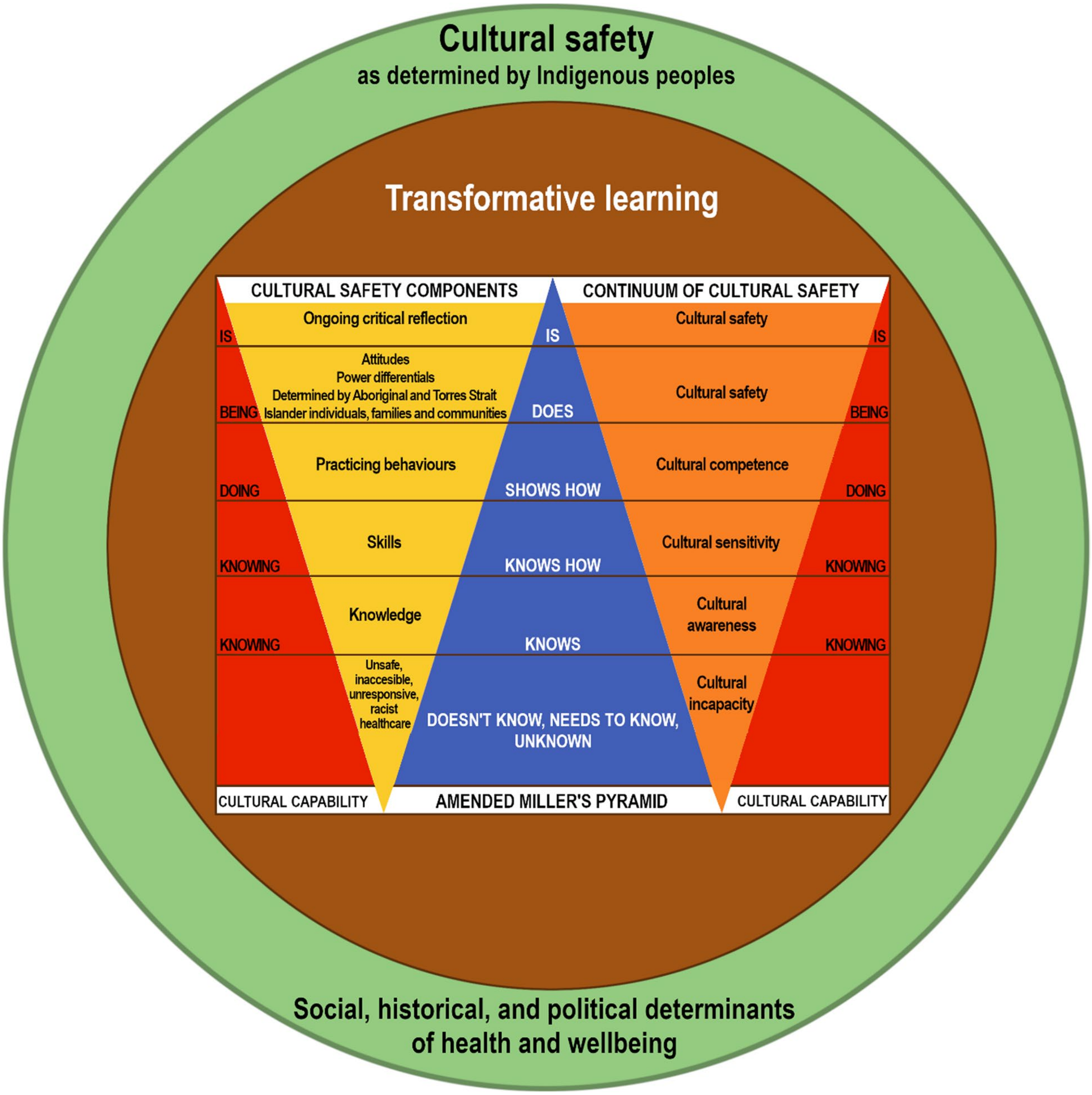


Fig. 1 Proposed model of cultural safety in general practice

safety, does not provide specific, or measurable attributes to guide registrar assessment. This risks registrar "knowing, doing and being" culturally safe care being ethereal unless further definition of what constitutes culturally safe care is forthcoming. As cultural safety must be determined by Aboriginal and Torres Strait Islander individuals, families and communities, these parameters must be derived and endorsed by the Aboriginal and Torres Strait Islander community. Ensuring Indigenous ownership adds additional complexity to the design and delivery of the assessment of cultural safety when the Aboriginal and Torres Strait Islander community, although viewed as a collectivist society, is a heterogenous society [43] and when it is normative for all patients to impose their individual bias on consultations [28].

In view of this complexity, we will present our research methodology including the development of data collection tools. We will use our proposed model to frame this research. The protocol outlined here will be used in several inter-related studies exploring the research question of "How can cultural safety, as determined by Aboriginal and Torres Strait Islander people, be assessed amongst GP trainees?" We aim to develop a tool to assess whether GP registrars are conducting a culturally safe consultation, where cultural safety is determined by Aboriginal and Torres Strait Islander peoples.

Methods

Methodological overview

This study will be situated in a pragmatic philosophical position to explore cultural safety primarily from the Aboriginal and Torres Strait Islander patients' perspective with triangulation and validation of findings with the GP and GP registrar perspective, the Aboriginal and Torres Strait Islander community, and the medical education community. Epistemologically, pragmatism is based on the premise of focussing on practical understandings of concrete, real-world problems and uses the best available methods to achieve this outcome [44]. This allows for integration of both quantitative and qualitative data to explore complex problems in need of a multi-dimensional approach [45].

Study design

This study is funded through an Australian government Medical Research Futures Fund Clinician Researchers grant, and an Australian College of Rural and Remote Medicine educational research grant. A mixed methods sequential embedded design approach [46] will be used to address the research question and sub-questions. This will be in three phases as indicated in Fig. 2.

This approach is chosen to generate data on the complex concept of cultural safety and allow for: (a) identification of culturally safe and unsafe care that can inform cultural safety training; (b) allow for triangulation of patient data with GP registrar and GP data; and (c) refinement and validation of the data with both Aboriginal and Torres Strait Islander peoples and medical education experts.

This study has been built upon the National Health and Medical Research Council guidelines for the ethical conduct of research with Aboriginal and Torres Strait Islander peoples [47]. It was therefore designed with the six values of ethical conduct in research at its core: namely spirit and integrity, responsibility, reciprocity, respect, equity, and cultural continuity [47]. The research was developed in response to a need determined by Aboriginal and Torres Strait Islander health workers and cultural mentors within a regional Aboriginal Medical Service (AMS) (hereafter referred to as the seed AMS) where KB is a practicing GP and RW the chairperson of the organisation. The team has

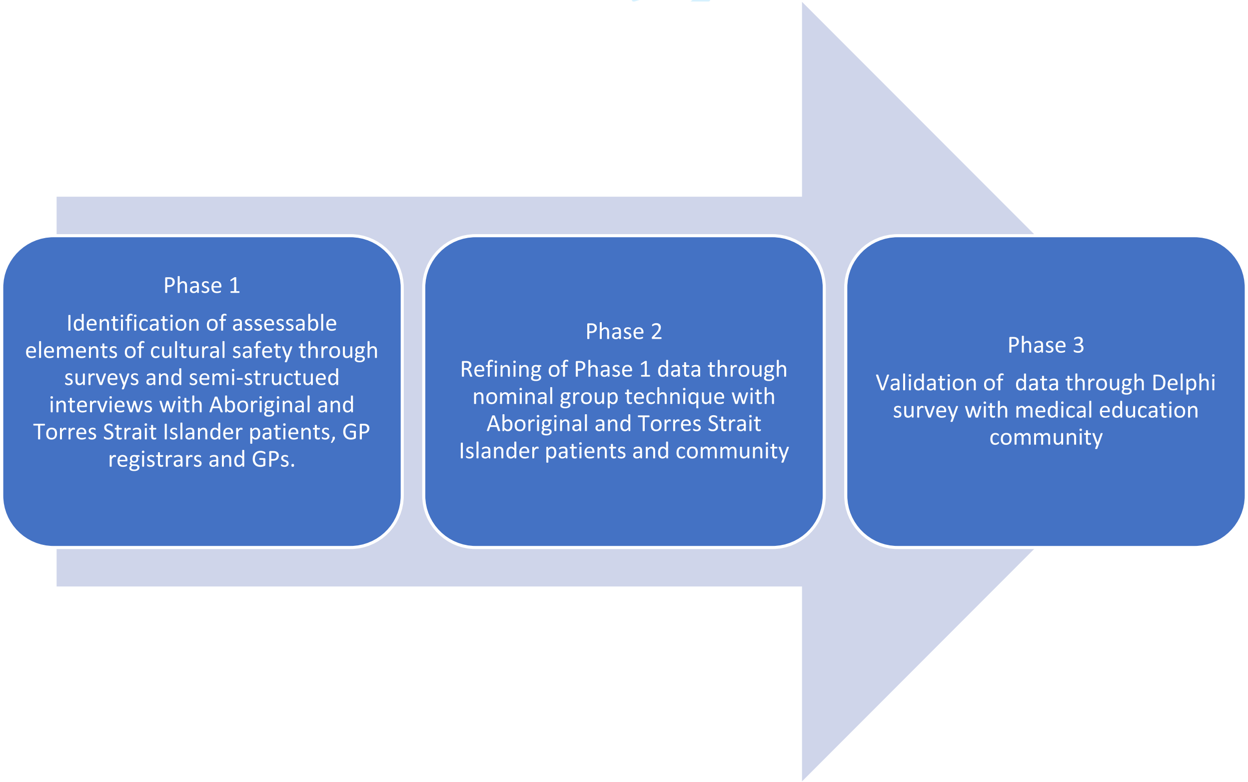


Fig. 2 Three phases of the research protocol

recruited an Indigenous expert panel to ensure these principles and local community protocols are adhered to and has involved health workers, cultural educators, cultural mentors, health advocates and Indigenous academics as part of the research team. Support for the project was sought from, and provided by, the seed AMS staff and board, other Aboriginal Community Controlled Health Organisations, and general practices within the region of study, the National Cultural Educator and Cultural Mentor Network, and the Leaders in Indigenous Medical Education Network (a national group drawn from the university sector).

The James Cook University Human Research Ethics Committee approved this study (H8296) following review by Aboriginal and Torres Strait Ethics Advisors in accordance with the National Health and Medical Research Council guidelines.

Participants and recruitment

There will be four different groups of participants. Each will be described separately. Participants can withdraw from the study at any time with no consequences. Participants will be remunerated for their time with a gift voucher to the value of $50.

Aboriginal and Torres Strait Islander patient participants

Primary care, or GP care, for Aboriginal and Torres Strait Islander patients can be sought through a variety of services including private general practices, and services initiated and operated by Aboriginal and Torres Strait Islander communities for Aboriginal and Torres Strait Islander peoples (Aboriginal Community Controlled Health Organisations or ACCHOs). In this study, self-identifying, adult Aboriginal and Torres Strait Islander patients attending participating private general practices and ACCHOs in Queensland will be invited to participate.

ACCHOs and private general practices, agreeing to participate in the study, are those that have a pre-existing relationship with staff and/or board members at the seed AMS. Senior staff at these practices have been approached to inform them of the study and seek support for the study. Where appropriate, they have been invited to participate in governance structure of the project, through the expert panel. The practices are all within rural and regional Queensland. The three ACCHOs are geographically dispersed being at least 550 kms distant from each other. The private practices are near the seed AMS.

Patients will be invited by practice staff (not in a position of power), either verbally or through providing an information sheet at the end of their consultation, to participate in the study. This may be in the form of a telephone conversation or email if consultation is occurring via telehealth. All patients satisfying inclusion criteria at the ACCHOs will be approached, dependant on practice workflow and demands, until the sample size is achieved. Patients meeting inclusion criteria at the mainstream general practice will be purposively approached until sample size achieved; or a telephone call or letter sent using practice contact details inviting them to participate in the project. Inclusion criteria are: (a) the patient self-identifies as an Aboriginal and Torres Strait Islander person; (b) aged > 18 years; and (c) capacity to give informed consent.

Patients will be asked during the interview if they wish to be invited to participate in Phase 2 of the research project.

Registrar participants

One Queensland GP registrar training organisation, James Cook University General Practice Training (JCUGP), agreed to participate in the study after direct approach by the principal investigator, who has existing professional relationships with JCUGP senior staff. Registrars within JCUGP work across Queensland, including the Torres Strait Islands, but excluding the south-east corner of the state [48]. Within JCUGP region approximately 70,000 or two-thirds of Queensland's Aboriginal and Torres Strait Islander people live in diverse communities – from regional cities to remote islands [48]. Given the diversity of communities, the high population of Aboriginal and Torres Strait Islander peoples, and the number of registrars, sampling only one organisation was considered appropriate. All JCUGP registrars undertake mandatory cultural awareness training modules that are delivered by cultural educators. JCUGP also delivers cultural safety training which is informed by the Aboriginal and Torres Strait Islander Community. Many registrars will gain additional skills and experience throughout their hospital and general practice training.

In this study, all GP registrars undertaking active training with JCUGP will be invited to participate in the study. Registrars could be undertaking training in a range of settings including specialty-based hospital disciplines, rural generalist hospitals, AMSs, and mainstream general practices.

All JCU-GP registrars will be sent an invitation email which will include links to the participant information sheet, consent form and survey. Participants are asked to provide informed consent to completion of both survey and interview. They will be asked to include name and contact details (email or telephone) to allow the research assistant to contact them to schedule the interview. This identifying information will be stored securely and separately to the research data and a unique identifier code used to link the survey and interview data.

General practitioner participants

GPs, who have been working at the participating practices (see section *Aboriginal and Torres Strait Islander patient participants*) for more than six weeks, will be invited to participate in the project to explore practices that they perceive are culturally safe. All GPs will be invited by practice staff (not in a position of power), either verbally or through giving of an information sheet (hard-copy or emailed), to participate in the study.

Delphi participants

Participants will include Australian Aboriginal and Torres Strait Islander people who are patients, both Indigenous and non-Indigenous patient advocates, experts in Australian Aboriginal and Torres Strait Islander healthcare and health education (including GPs, medical educators, academics, and health workers), and other key stakeholders. Recruitment will occur by a variety of means including word-of-mouth, snowballing and invitation emails through existing networks of the research team and seed AMS.

Data collection

Data will be collected sequentially in three phases.

Phase 1

Phase 1 uses a concurrent embedded mixed methods approach and will gather both survey data and semi-structured interview data to explore the research questions [46]. Data will be collected in three parts, and across three groups of participants (Table 1). In this method, data will be collected and analysed concurrently and results from qualitative data synthesised with quantitative data. To avoid power imbalances and facilitation of frank answers, researchers with no pre-existing relationship to any of the participants, will complete data collection in Phase 1.

The data collection methodology will be described separately for Aboriginal and Torres Strait Islander patients, GP registrars and GPs. Informed consent will be obtained and recorded in electronic format, on Qualtrics, prior to completing the online survey. The consent will encompass both the survey and the subsequent interview. The research assistant will be available to aid where required.

Aboriginal and Torres Strait Islander patients

Part 1

Part 1 will involve administration of a Qualtrics® based survey considering demographic details of the participating patient, including age and gender. Further questions explore five selected social determinants of health that have been shown to contribute significantly to the health gap between Indigenous and non-Indigenous adults [52]. These determinants are household income, employment and hours worked, highest non-school qualification, level of schooling completed, and housing adequacy [52]. These social determinants are explored recognizing that the interaction between cultural safety, social factors and wellbeing is very complex and a method for assessing cultural safety needs to be cognizant of this relationship. The questions are mirrored from the Australian Bureau of Statistics census data [53].

Part 2

Part 2 will involve semi-structured interviews with patients to explore their understanding of cultural safety. The semi-structured interview guide was developed *de-novo* being informed by the literature, experience, and advice from a community advisory panel of Aboriginal and Torres Strait Islander people who are overseeing the project (Additional file 1: Appendix 1). One question asks patients to choose their preferred GP from 45

Table 1 Phase 1 – Data collection methodology

	Aboriginal and Torres Strait Islander patients	GP registrars and GPs
Part 1:	Survey Demographic details	Survey Demographic details Experience Cultural capability measurement tool [49] Measurement of attitude change scale [50] Self-reflection and insight scale [51]
Part 2	Semi-structured interviews exploring patient understanding and experience of cultural safety	Semi-structured interviews exploring registrar understanding of cultural safety
Part 3:	Detailed exploration of patient's perception of key areas identified in the cultural safety literature	Detailed exploration of registrar's perception of key areas identified in the cultural safety literature
Number of participants	We are aiming to recruit approximately ten patients from each of the four participating practices, but data collection will continue until the data produces no new insights and data is repeating	We are aiming to recruit approximately twenty GP registrars and three GPs from each of the four participating practices, but data collection will continue until the data produces no new insights and data is repeating

photographic different face images. This is designed to explore potential patient bias in a consultation. These images represent a diversity of gender, age, ethnicity, and appearance. Images include Aboriginal and Torres Strait Islander doctors, obtained from Indigenous health websites, and others from a free face generator (thispersondoesnotexist.xyz) [54].

The interview guide was reviewed by the whole research team, two independent GPs, and members of the community advisory panel. The survey and interview guide were piloted with two Aboriginal health workers. Interviews are expected to take 30–45 min. Participants will be offered face-to face or remote interviews, either video or audio only. Interviews will be recorded following confirmation of informed consent and then electronically transcribed. These transcripts will be checked for accuracy by a research assistant.

Part 3

At the end of semi-structured interviews, the interviewer will request patients rate the importance, from not important (one) to very important (five), of several factors when consulting their GP. These factors where identified from Australian medical education literature and included sociocultural differences [55], the importance of general consultation and communication skills, the ability to listen, respect, trust, and self-reflection [6]. Patients will be encouraged to justify or explain their response regarding the importance of knowing Australian history pre-colonisation, the experiences of Aboriginal and Torres Strait Islander people after colonisation and having medical knowledge and skills. In addition, they are asked to rate the importance of eye contact, the value of silence, the use of some traditional language, inclusion of spirituality in a consultation and the importance of including family, elders of other significant others in the consultation. Finally, participating patients will be asked to consider how important their own culture is to them and their identity and the importance of their own connection to land.

GP registrars and GPs

Part 1

Like patients, part 1 will involve administration of a Qualtrics®-based survey considering demographic details of the GP registrars including age, gender, postgraduate level, stage of training, training college, university of graduation, time lived in Australia, exposure to Aboriginal and Torres Strait Islander patients and type of current practice (AMS, hospital, or mainstream general practice). This information will be used to describe the participants, to determine if participants are representative of the JCUGP registrar cohort, and to provide context for qualitative data analysis.

The survey will include questions exploring the "being" and "is" of cultural safety regarding attitude and beliefs for comparison with the qualitative data. Numerous self-assessment tools exist to measure a learner's behaviour and attitude [56]. Validated survey questions from West et al.'s cultural capability measurement tool (developed for nurses) [56] and Ryder et al.'s measurement of attitude change [50] has been utilised. Ryder et al. developed and validated a questionnaire to measure attitude change in health professionals (including medical students) following completion of a cultural safety training program [48]. Both questionnaires by West et al. [56] and Ryder et al. [50] occur outside of the context of patient interaction and are self-assessed measures of attitude. The questions asked in both surveys share similarities and therefore, the questions were compared and rationalised by choosing one representative question from overlapping queries (Additional file 1: Appendix 2). As Ryder et al.'s research included medical students these questions were preferentially used. Wording of the survey is modified such that 'health professional' or 'student' is replaced with 'GP, 'Aboriginal people' is broadened to 'Aboriginal and Torres Strait Islander people', 'patient' is used instead of 'client', "GP consultation" substituted for "hospitalised patient's room" and "Prohibited" replaced with "limited or restricted" to avoid an 'all or nothing' type of question.

We altered the West et al. survey question: "Aboriginal and Torres Strait Islander peoples receive special treatment from government" to "Aboriginal and Torres Strait Islander peoples receive *unnecessary* special treatment from government". Investigators felt the original question could be interpreted by participants in this study as a knowledge assessment—about Australian government initiatives to close the gap on Indigenous health disparities [57] rather than a reflection of participants' attitude.

To consider registrar self-reflection, we examined 21 different questionnaires identified in a systematic search by Soemantri et al. [51]. Five questions from the Self-Reflection and Insight Scale (SRIS), looking at intention for reflection, were chosen by the research team as most appropriate and incorporated [58] into the final survey (Additional file 1: Appendix 2).

Part 2

Like patients, Part 2 will involve semi-structured interviews with GP registrars and GPs to explore their understanding of cultural safety. The semi-structured interview guide was developed in the same manner as the patient guide and is presented in Additional file 1: Appendix 3.

The survey and interview guide were piloted with two GP registrars and a recent GP fellow. Interviews are expected to take 30–45 min.

The interview will be conducted at least 5 days after the survey to minimise survey questions influencing responses in the semi-structured interviews. Participants will be offered face-to face or remote interviews, either video or audio only. Interviews will be recorded following confirmation of informed consent and then electronically transcribed. These transcripts will be checked for accuracy by a research assistant.

Part 3

Part 3, at the end of semi-structured interviews, the interviewer will request GP registrars and GPs to rate the same questions presented to the patient participants.

Phase 2

Findings from Phase 1 will be validated using a two-step qualitative approach to confirm essential elements of any potential cultural safety assessments in GP consultations.

Phase 2 will utilise an adapted nominal group technique (NGT). McMillan et al. [59] detailed a simplified model of NGT (silent generation, round robin, clarification, ranking and discussion). This project will incorporate the Indigenous research approach of yarning [60] in place of discussion. Bessarab and Ng'andu [60] describe research topic yarning as an "*informal and relaxed discussion through which both the researcher and participant journey together visiting places and topics of interest relevant to the research study*". It will also adopt similar methods as described by Woolley [61] to encourage discussion and debate on inclusion of elements from Stage 1 in a potential assessment tool:

> "*The Yarning Circle discussion involved the facilitator asking the other participants to describe any specific skills, knowledge or attitudes they felt were important…Participant comments under each… heading were captured as a phrase or statement on butcher's paper in front of the group so that participants were able to see the ideas generated. Visual representation of the data generated in the focus group enabled participants to come to an agreement about how each comment was summarised*".

As a primary aim for the project will be to develop a patient-driven assessment tool, only Australian Aboriginal peoples will be invited to consider element inclusion/exclusion in the first instance. Australian Aboriginal patients participating in Stage 1 will be invited to participate in the adapted NGT group. Other participants will be purposively sampled, though the networks of both the research team and participating practices and invited to participate. These will include additional Australian Aboriginal patients and Australian Aboriginal representatives from key stakeholder groups, including community. Once participants are known, advice will be sought from the expert panel regarding appropriateness of separate groups for patients and stakeholders to minimise any potential power differential. Snowball recruiting will be encouraged.

Ideally the adapted NGT will be conducted face-to-face but could be managed through an online meetings platform if circumstances require this approach. Following a written and verbal informed consent process, adapted NGT groups will be audio-recorded and transcribed as per individual semi-structured interviews and any written material collated or photographed.

Sample size

A maximum group size of seven has been recommended for NGT [59]. One to five adapted NGT groups will be conducted in geographically diverse locations. The number of adapted NGT will be dependent on number and scheduling requirements of participants.

Phase 3

Phase 3 involves a Delphi survey to further validate the findings of Phase 1 and 2. A Delphi technique (DT) uses a multi-stage process of anonymous questionnaires to create a highly structured group interaction [59]. Elements identified for inclusion in an assessment approach from Phase 2 adapted NGT will be collated and refined into a Delphi questionnaire. Links to consent and DT questionnaires will be emailed to participants and reminders sent to all participants. Qualtrics® will be used to administer the questionnaire online and collate responses electronically. Elements will be rated by participants on a Likert scale and free-text comments written to justify their response. The process will be repeated until consensus is reached about the elements which are important to include in an assessment of cultural safety.

Sample size

A panel size of 15 is suggested as optimal size for this technique [59].

Data analysis

Survey data will be descriptively analysed using Excel® to both characterise the participants and provide contextual data for assisting in interpreting the interview data. One researcher (KB) will analyse all interview and adapted NGT transcripts through a content analysis approach using theory-driven codes derived from the AHPRA definition of cultural safety (free from racism, knowledge, skills, attitude, behaviours, power differential) and emerging data-driven codes. NVivo® analysis software will be used when coding data, recording frequency of occurrence of item of interest, and collating key concepts. Interview data and coding will be checked and reviewed by other researchers and the research team will meet frequently to reflect and debrief to support the dependability and credibility of the data analysis.

This project will maintain transparency through the research process by input from the community panel, regular discussion with the seed AMS staff, peer examination of the data through conference presentations, ongoing journaling of personal reflexivity on the data, and identifying disconfirming evidence that is contrary to evidence supporting a theme. Multiple reviews of coding will be conducted to ensure agreement in the coding and to minimise bias of any individual researcher. In addition, KB will work with the community advisory panel during phases of thematic analysis and coding, further minimising the potential bias associated with the individual researcher.

Consensus elements from the three phases will be synthesised into a potential assessment model. Further research beyond this project will be required to pilot and validate the proposed assessment approach.

Reflexivity

The principal investigator, KB, is an experienced GP academic working in the seed AMS in south-east Queensland. Her cultural heritage is uncertain and is impacted by the complexities surrounding Aboriginal identity within Australia [62]. RW is an Aboriginal academic from Kunja Nations, NH an Aboriginal and Torres Strait Islander cultural educator for JCUGP, RE a senior researcher, TS and HW academic GPs, and LM an academic GP. A community advisory group of Aboriginal and Torres Strait Islander people, associated with the seed AMS, have been involved in the research since inception.

Discussion

This study will be one of the first to explore how cultural safety, as determined by Aboriginal and Torres Strait Islander peoples, can be assessed in general practice consultations. The study will explore how GPs and GP registrars perceive cultural safety with Aboriginal and Torres Strait Islander patients and alignment with the community derived AHPRA definition of cultural safety. As such we will compare the GP and GP registrar data and patient data to identify the concordance with each other and the AHPRA definition to help shape teaching and assessment of cultural safety.

This protocol is shared to stimulate awareness and discussion around this significant issue and prompt other studies in this area. We hypothesise that conceptualising the assessment of cultural safety through the multiple dimensions of a community-derived definition [19], the continuum of cultural safety [3, 4], educationally (using Miller's pyramid [33] and transformative learning theory [35]), Aboriginal ways of knowing, doing, and being [34], and social and emotional wellbeing [26] will allow an assessment outcome to reflect the complexity of cultural safety within general practice.

Key limitations to this study include that we are studying a relatively small number of participants in a geographically discrete region. While there are strengths in this geographically discrete approach, especially regarding specificity to the local cultural context, outcomes of this project should be assessed for wider application. In addition, we are relying on participants to self-describe their behaviours, and attitudes. With the GP and GP registrar surveys, responses in these questionnaires may not accurately reflect behaviour, or the opinion and experience of the patient [63]. Direct observation of practice may provide further insight into attributes of cultural safety.

This project has implications for practice and training of medical professionals both within Australia and internationally. Within Australia, culturally safe practice has been recognised by both the RACGP and ACRRM as a priority for inclusion in training programs. This protocol allows the exploration of cultural safety, as understood by patients, GPs, and registrars, and to identify gaps between the knowing, doing and being of general practice. This understanding is vital to allow the shaping and improvement of cultural safety training within GP training curricula and consideration of assessment of GP registrars knowing, showing, and doing.

However, this protocol also has potential within a wider context. Other areas of healthcare, including other medical specialities, allied health, dental and nursing, could benefit from similar studies exploring cultural safety amongst trainees. In the same way, an exploration of the process of developing safe care for culturally diverse peoples has potential benefits internationally. It is hoped that the sharing of this protocol offers opportunities to expand the knowledge base around culturally safe care more widely.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12909-023-04249-6.

Additional file 1: Appendix 1. Semi-structured interview guide for patients. **Appendix 2.** Survey questions for GPs and GP registrars. **Appendix 3.** Semi-structured interview guide for GPs and GP registrars.

Acknowledgements
This study is supported by patients, staff and the community advisory panel at Goolburri Aboriginal Health Advancement, Toowoomba, Australia. It is a PhD dissertation protocol of the first author at The College of Medicine and Dentistry, James Cook University, Australia.

Authors' contributions

KB—wrote the main manuscript text and prepared figures. All authors reviewed and approved the manuscript.

Authors' information

Kay Brumpton is first author.

Funding

This study is funded through an Australian government Medical Research Futures Fund Clinician Researchers grant, and an Australian College of Rural and Remote Medicine educational research grant.

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to reasons of sensitivity but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

The James Cook University Human Research Ethics Committee approved this study (H8296) following review by Aboriginal and Torres Strait Ethics Advisors in accordance with the National Health and Medical Research Council guidelines. Informed consent will be obtained and recorded in electronic format, on Qualtrics, prior to participating in the study. The consent will encompass both the survey and the subsequent interview. The research assistant will be available to aid where required.

Consent for publication

Not applicable for this protocol paper. Ethics approval received for publication of de-identified material with patient informed consent for the study.

Competing interests

The authors declare no competing interests.

Author details

[1] Rural Medical Education Australia, Toowoomba, Australia. [2] University of Southern Queensland, Toowoomba, Australia. [3] College of Medicine and Dentistry, James Cook University, Townsville, Australia.

Received: 23 February 2023 Accepted: 11 April 2023

References

1. Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Serv Res. 2014;14:99.
2. MacKean T, Fisher M, Friel S, Baum F. A framework to assess cultural safety in Australian public policy. Health Promot Int. 2019;35(2):340–51.
3. Ramsden I. Cultural safety and nursing education in Aotearoa and Te Waipounamu. Wellington: Victoria University; 2002.
4. Mashford- Pringle A, Skura C, Stutz S, Yohathasan T. What we heard: Indigenous Peoples and COVID-19. Waakebiness-Bryce Institute for Indigenous Health. Dalla Lana School of Public Health: University of Toronta; 2021.
5. Paul D, Hill S, Ewen S. Revealing the (in)competency of "cultural competency" in medical education. AlterNative. 2012;8(3):318–28.
6. Brumpton K, Evans R, Ward R, Sen Gupta T. A consistent definition of cultural safety within Australian health professional education: a scoping review. AlterNative. 2022:18(3):436–44.
7. Grant J, Parry Y, Guerin P. An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. Aust N Z J Public Health. 2013;37(3):250–6.
8. McKivett A, Paul D, Hudson N. Healing conversations: developing a practical framework for clinical communication between Aboriginal communities and healthcare practitioners. J Immigr Minor Health. 2019;21(3):596–605.
9. Liaw ST, Hasan I, Wade V, Canalese R, Kelaher M, Lau P, et al. Improving cultural respect to improve Aboriginal health in general practice: A multi-methods and multi-perspective pragmatic study. Aust Fam Physician. 2015;44(6):387–92.
10. Freeman T, Edwards T, Baum F, Lawless A, Jolley G, Javanparast S, et al. Cultural respect strategies in Australian Aboriginal primary health care services: Beyond education and training of practitioners. Aust N Z J Public Health. 2014;38(4):355–61.
11. Barnett L, Kendall E. Culturally appropriate methods for enhancing the participation of Aboriginal Australians in health-promoting programs. Health Promot J Austr. 2011;22(1):27–32.
12. Smith K, Fatima Y, Knight S. Are primary healthcare services culturally appropriate for Aboriginal people? Findings from a remote community. Aust J Prim Health. 2017;23(3):236–42.
13. Bennett B, Redfern H, Zubrzycki J. Cultural responsiveness in action: Co-constructing social work curriculum resources with Aboriginal communities. Br J Soc Work. 2018;48(3):808–25.
14. Chang ES, Simon M, Dong X. Integrating cultural humility into health care professional education and training. Adv Health Sci Educ. 2012;17(2):269–78.
15. Chapman R, Martin C, Smith T. Evaluation of staff cultural awareness before and after attending cultural awareness training in an Australian emergency department. Int Emerg Nurs. 2014;22(4):179–84.
16. Chong A, Renhard R, Wilson G, Willis J, Clarke A. Improving cultural sensitivity to Indigenous people in Australian hospitals a continuous quality improvement approach. Focus on Health Professional Education : A Multi-disciplinary Journal. 2011;13(1):84–97.
17. Isaacs AN, Raymond A, Jacob E, Jones J, McGrail M, Drysdale M. Cultural desire need not improve with cultural knowledge: A cross-sectional study of student nurses. Nurse Educ Pract. 2016;19:91–6.
18. Omeri A, Ahern M. Utilising culturally congruent strategies to enhance recruitment and retention of Australian indigenous nursing students. J Transcult Nurs. 1999;10(2):150–5.
19. Ahpra & National Boards. A consistent baseline definition of cultural safety for the National Scheme. Canberra: National Registration and Accreditation Scheme; 2019.
20. Australian Bureau of Statistics (2021). Aboriginal and Torres Strait Islander people:census - reference period 2021. https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-people-census/2021. ABS: Canberra; 2022. Accessed 30 Apr 2023.
21. Australian Government Department of Health and Aged Care. Status and determinants of Aboriginal and Torres Strait Islander health. https://www.health.gov.au/topics/aboriginal-and-torres-strait-islander-health/status-and-determinants. DOHA: Canberra; 2021. Accessed 30 Apr 2023.
22. Ahpra & National Boards. The National Scheme's Aboriginal and TorresStrait Islander health and cultural safety strategy 2020–2025. Canberra:Ahpra and National Boards; 2020.
23. Australian Institute of Health and Welfare. Cultural safety in health care for Indigenous Australians: monitoring framework. Canberra: AIHW; 2022.
24. Australian Medical Council Limited. Review of the accreditation standards for primary medical programs. https://www.amc.org.au/review-of-accreditation-standards-for-primary-medical-programs-medical-schools/. AMC; 2022. Accessed 30 Apr 2023.
25. Anderson IP, Robson BP, Connolly MMPH, Al-Yaman FP, Bjertness EP, King AMD, et al. Indigenous and tribal peoples' health (The Lancet-Lowitja Institute Global Collaboration): a population study. Lancet. 2016;388(10040):131–57.
26. Gee G, Dudgeon P, Schultz C, Hart A, Kelly K. Social and emotional wellbeing and mental health: an Aboriginal perspective. Chapter 4, In: Dudgeon P, MilroyM, Walker R,(editors). Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Ed., in National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017–2023. Revised ed. https://www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf. Canberra: Department of Prime Minister andCabinet; 2017. p. 55. Accessed 30 Apr 2023.
27. Royal Australian College of General Practitioners. Standards for general practices. 5th ed. East Melbourne: RACGP; 2020.
28. Brumpton K, Sen Gupta T, Evans R, Ward R. Assessment of cultural safety in a post-Objective Structured Clinical Examination (OSCE) era. AJGP. 2022;51(1–2):90–3.

29. Royal Australian College of General Practitioners. 2022 RACGP curriculum and syllabus for Australian general practice. Melbourne: RACGP; 2022.
30. Australian College of Rural and Remote Medicine. Rural generalist curriculum. Brisbane: ACRRM; 2020.
31. Australian Medical Council Limited. Proposed graduate outcome statements:draft for consultation. https://www.amc.org.au/wp-content/uploads/2022/09/ATTACHMENT-A-Proposed-Graduate-Outcome-Statements-Draft-for-consultation-August-2022.pdf. Canberra: AMC; 2022. Accessed 30 Apr 2023.
32. Watt K, Abbott P, Reath J. Developing cultural competence in general practitioners: an integrative review of the literature. BMC Fam Pract. 2016;17(1):1–11.
33. Cruess R, Cruess S, Steinert Y. Amending Miller's pyramid to include professional identity formation. Acad Med. 2016;91(2):180–5.
34. Martin K, Mirraboopa B. Ways of knowing, being and doing: a theoretical framework and methods for Indigenous and Indigenist re-search. J Aust Stud. 2003;27(76):203–14.
35. Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010;376(9756):1923–58.
36. General Practice Registrars Australia. Pathways into general practice. https://gpra.org.au/training/fellowship-pathways/GPRA; 2022. Accessed 30 Apr 2023.
37. Royal Australian College of General Practitioners. Examination guide. https://www.racgp.org.au/educa tion/registrars/fracgp-exams/exam-support-program-resources/examination-guide. Melbourne: RACGP; 2022. Accessed 30 Apr 2023.
38. Australian College of Rural and Remote Medicine A. Fellowship assessment handbook. https://www.acrrm.org.au/docs/default-source/all-files/handbook-fellowship-assessment.pdf?sfvrsn=42ba86eb_8. Brisbane: ACRRM; 2019. Accessed 30 Apr 2023.
39. Sen Gupta T, Campbell D, Chater A, Rosenthal D, Saul L, Connaughton K, et al. Fellowship of the Australian College of Rural & Remote Medicine (FACRRM) assessment: a review of the first 12 years. MedEdPublish. 2020;9(100).
40. Brouwers M, Custers J, Bazelmans E, Van Weel C, Laan R, van Weel-Baumgarten E. Assessment of medical students' integrated clinical communication skills: development of a tailor-made assessment tool. BMC Med Educ. 2019;19(118):1–10.
41. Al-Eraky M, Marei H. A fresh look at Miller's pyramid: assessment at the "Is" and 'Do" levels. Med Educ. 2016;50:1253–7.
42. Broadwell M. Teaching for learning (XVI). The Gospel Guardian. 1969;20(41):1–3a.
43. Jalla C, Hayden G. Aboriginal health research is not black and white - lessons from the field. Australian Indigenous HelathBulletin. 2014;14(3).
44. Patton M. Qualitative Research & Evaluation Methods. 4th ed. Los Angeles: SAFE; 2005.
45. Allemang B, Sitter K, Dimitropoulos G. Pragmatism as a paradigm for patient-oriented research. Health Expectat. 2022;25(1):38–47.
46. Creswell J, Plano CV. Designing and conducting mixed methods research. Thousand Oaks: Sage; 2007.
47. National Health and Medical Research Council. Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: guidelines for researchers and stakeholders. Canberra: Commonwealth of Australia; 2018.
48. James Cook University. General Practice training. Townsville: JCU; 2022. https://www.jcugp.edu.au/. JCU: Townsville; 2022. Accessed April 30, 2023.
49. West R, Wrigley S, Mills K, Taylor K, Rowland D, Creedy D. Development of a First Peoples-led cultural capability measurement tool: a pilot study with midwifery students. Women Birth. 2017;30(3):236–44.
50. Ryder C, MacKean T, Ullah S, Burton H, Halls H, McDermott D, et al. Development and validation of a questionnaire to measure attitude change in health professionals after completion of an Aboriginal health and cultural safety training programme. Aust J Indigenous Educ. 2019;48(1):24–38.
51. Soemantri D, Mccoll G, Dodds, A. Measuring medical students' reflection on their learning: modification and validation of the motivated strategies for learning questionnaire (MSLQ). BMC Med Educ. 2018;18(1):1–10.
52. Australian Institute of Health and Welfare. Determinants of health for Indigenous Australians. https://www.aihw.gov.au/reports/australias-health/social-determinants-and-indigenous-health health. Canberra: AIHW;2020.
53. Australian Bureau of Statistics. Census household form. Canberrra: Commonwealth of Australia; 2016.
54. Vincent J. ThisPersonDoesNotExist.com uses AI to generate endless fake faces: Vox Media; 2019. Available from: https://www.theverge.com/tldr/2019/2/15/18226005/ai-generated-fake-people-portraits-thispersondoesnotexist-stylegan. Accessed 30 Apr 2023.
55. Jongen C, McCalman J, Bainbridge R, Clifford A. Cultural Competence in Health - A review of the Evidence. Singapore: Springer Briefs in Public Health; 2018.
56. West R, Mills K, Rowland D, Creedy DK. Validation of the first peoples cultural capability measurement tool with undergraduate health students: a descriptive cohort study. Nurse Educ Today. 2018;64:166–71.
57. Productivity Commission. Closing the gap annual data compilation report July 2022. https://www.pc.gov.au/closing-the-gap-data/annual-data-report/report/closing-the-gap-annual-data-compilation-report-july2022.pdf. Canberra: Commonwealth of Australia, Office of the Prime Minister and Cabinet; 2022. Accessed 30 Apr 2023.
58. Naeimi L, Abbaszadeh M, Mirzazadeh A, Sima A, Nedjat S, SH. Validating self-reflection and insight scale to measure readiness for self-regulated learning. J Educ Health Promotion. 2019;8:1–7.
59. McMillan S, King M, Tully M. How to use the nominal group and Delphi techniques. Int J Clin Pharm. 2016;38:655–62.
60. Bessarab D, Ng'andu B. Yarning about yarning as a legitimate method in Indigenous research. Int J Crit Indig. 2010;3(1):37–50.
61. Woolley T, Sivamalai S, Ross S, Duffy G, Miller A. Indigenous perspectives on the desired attributes of medical graduates practising in remote communities: a Northwest Queensland pilot study. Aust J Rural Health. 2013;21(2):90–6.
62. Carlson B. The politics of identity: who counts as Aboriginal today? Canberra: Aboriginal Studies Press; 2016.
63. Carr S, Johnson, P. Does self reflection and insight correlate with academic performance in medical students? BMC Med Ed. 2013;13(113):113–7.

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

No.	Description of the standard	Page number
#1	Title: Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	2
#2	Abstract: Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusion	2
#3	Problem formulation: Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	4-5
#4	Purpose of research question: Purpose of the study and specific objectives or questions	5
#5	Qualitative approach and research paradigm: Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale*	6
#6	Researcher characteristics and reflexivity: Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	7
#7	Context: Setting/site and salient contextual factors; rationale**	6
#8	Sampling strategy: How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale	6
#9	Ethical issues pertaining to human subjects: Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security is	20
#10	Data collection methods: Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	6
#11	Data collection instruments and technology: Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	6
#12	Units of study: Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	7
#13	Data processing: - Methods for processing data prior to and during	7

	analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	
#14	Data analysis: - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	7
#15	Techniques to enhance trustworthiness: - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale*	6
#16	Synthesis and interpretation: Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	7
#17	Links to empirical data: Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic finding	7-18
#18	Integration with prior work, implications, transferability, and contribution(s) to the field: Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	18
#19	Limitations: Trustworthiness and limitations of findings	2-3
#20	Conflicts of interest: Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	20
#21	Funding: Sources of funding and other support; role of funders in data collection, interpretation, and reporting	21

BMJ Open

Exploring what GP registrars consider distinctive to consultations with Aboriginal and Torres Strait Islander patients: a mixed method study.

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2023-082137.R1
Article Type:	Original research
Date Submitted by the Author:	27-Mar-2024
Complete List of Authors:	Brumpton, Kay; Griffith University Griffith Health, School of Medicine and Dentistry; Rural Medical Education Australia Woodall, Hannah; Rural Medical Education Australia; James Cook University College of Medicine and Dentistry Evans, Rebecca; James Cook University, College of Medicine and Dentistry and Anton Breinl Research Centre for Health Systems Strengthening Neill, Henry; James Cook University Sen Gupta, Tarun; James Cook University College of Medicine and Dentistry McArthur, Lawrie; The University of Adelaide Ward, Raelene; University of Southern Queensland
Primary Subject Heading:	General practice / Family practice
Secondary Subject Heading:	Medical education and training, Patient-centred medicine
Keywords:	Health Equity, MEDICAL EDUCATION & TRAINING, Primary Health Care

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

Exploring what GP registrars consider distinctive to consultations with Aboriginal and Torres Strait Islander patients: a mixed method study.

Kay Brumpton[1,2,3]*, Hannah Woodall[1, 2,3], Rebecca Evans[3], Henry Neill[3], Tarun Sen Gupta[3], Lawrie McArthur[4], Raelene Ward[5]

[1] Griffith University, Gold Coast Campus, Southport, Australia

[2] Rural Medical Education Australia, Toowoomba, Australia

[3] James Cook University, Townsville, Australia

[4] The University of Adelaide, Adelaide, Australia

[5] University of Southern Queensland, Toowoomba, Australia

*Corresponding Author.

Kay Brumpton

190 Hume Street, East Toowoomba, QLD, 4350.

k.brumpton@griffith.edu.au

ABSTRACT

Background and objective Understanding what general practice (GP) registrars consider as distinctive in their consultations with Aboriginal and Torres Strait Islander patients may help bridge the gap between patient-determined cultural safety and current medical and behavioural practice. This project seeks to explore what GP registrars perceive as distinctive to their consultations with Aboriginal and Torres Strait Islander patients. Methods This mixed methods study involved a survey considering demographic details of GP registrars, questionnaire regarding attitude and cultural capability, and semi-structured interviews.

Results Twenty-six registrars completed the survey. Sixteen registrars completed both the survey and the interview.   Despite recognising a need to close the gap on health outcomes for Aboriginal and Torres Strait Islander peoples and wanting to do things differently, most registrars adopted a generic approach to all consultations.

Discussion This study suggests that overall, GP registrars want do improve the health of Aboriginal and Torres Strait Islander patients, but do not want their consultations with Aboriginal and Torres Strait Islander patients to be distinctive. Registrars appeared to approach all consultations in a similar manner using predominantly patient-centred care principles. Given the importance of a culturally safe consultation, it is important for us to consider how to increasingly transform these learners and teach cultural safety in this context.

<u>Strengths and limitations of this study:</u>

- Our study was co-created with Aboriginal and Torres Strait Islander people and aimed to ensure the research was respectful of Aboriginal cultural values and beliefs and responsive to community priorities.
- Our mixed-methods study allowed comparison of survey and interview data to better understand registrars and how they considered Indigenous health.
- This study relied on registrar self-assessment and self-reporting and did not attempt to measure registrar insight or observed practicing behaviour and outcomes.

Introduction

Australian general practice aims to provide “person-centred, continuing, comprehensive and coordinated whole-person healthcare to individuals and families.”(1). Foundational to this approach is the patient-general practitioner (GP) partnership and acknowledgement of patient ideas, expectations, and values (2). Patient-centred care can help improve patient outcomes and is recognised as a key component of high-quality general practice care (3). Similarly, culturally safe care is considered an Australian national health priority for improving the health of Australia’s Indigenous population, who continue to experience the negative impacts of colonisation (4). The Australian National Scheme’s Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 vision is that patient safety is the norm for Australian Aboriginal and Torres Strait Islander peoples (4). The Australian National Scheme’s vision links clinical and cultural safety and recognises that cultural safety should be defined by Aboriginal and Torres Strait Islander peoples (4).

Numerous models for a patient-centred GP consultation are available to assist the GP to navigate a consultation effectively and efficiently (5). Within the Australian general practice context, medical students and GP registrars are frequently taught to structure their consultation on the Calvary-Cambridge model (starting the consultation, gathering information, physical examination, explanation and education, and closure of the consultation) (6). To the Calvary-Cambridge model is added Neighbour’s advice for preparing for the consultation and safety-netting (7), Pendleton’s ‘ICE’ acronym (the patient’s ideas, concerns, and expectations) (8), and Murtagh’s safe diagnostic strategy and consideration of masquerades (9). However, current models are not specifically designed to address the health and cultural needs of diverse, disadvantaged or marginalised populations, such as Aboriginal and Torres Strait Islander peoples (3) nor are they validated as culturally safe models of care.

New Zealand, a country with similar colonial history to Australia, has adopted a framework for consultations that aims to provide a culturally safer consultation for Māori patients and their families (10). This Meihana Model of consultation considers connection between the patient and their support networks through physical, spiritual, and environmental wellbeing, consciousness, and awareness. Furthermore, it examines the impact of marginalisation, colonisation, racism and migration on the patient and consultation (10). The Meihana model is integrated with the Hui process (10) - a process that is not dissimilar to the Calvary-Cambridge model (6) and involves initial greeting and engagement, making a connection and building relationships, attending to the agenda, and closing the consultation.

Within the Australian context, McKivett has proposed a clinical communication framework based on health equity and understanding the impact of patient-community, racism, colonisation, and marginalisation (11). However, this is a theoretical model and is currently lacking a guide for translation into clinical practice. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing uses Gee et. al.'s model of social and emotional wellbeing to provide a structure for registrars to consider the historical, political and social determinants of health and the seven overlapping domains of body, mind and emotions, family and kin, community, culture, country, and spirituality and ancestors (12).

However, within a GP consultation, even when consultation models are used, identifying culturally safe and unsafe care can be challenging, either through being invisible to or ignored by healthcare providers. Additionally, a lack of universal understanding of cultural safety has increased the challenge of identifying culturally safe care (13-15). To progress both patient care and the research agenda about cultural safety, the Australian Health Practitioner Agency (AHPRA) released a community-derived consensus statement defining cultural safety in 2019. We use this definition in our study.

> *"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise (sic) is ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising (sic) behaviors and power differentials in delivering safe, accessible and responsive healthcare free of racism*" (16).

In this study we aim to explore what GP registrars consider distinctive to their consultations with Aboriginal and Torres Strait Islander peoples. This article is part of a larger study aimed at developing a tool for assessing cultural safety in GP consultation.

Methods

Research design

A detailed description of the methodology has been published (17). This phase of the study involves a mixed method approach to understand what GP registrars consider as distinctive to consultations with Aboriginal and Torres Strait Islander patients.

Participants

All GP registrars undertaking active training in 2022 with a rural and regional Australian (Queensland-based) GP registrar training organisation (GPRTO) were invited to participate in the study.

Patient and public involvement

A community advisory group of Aboriginal and Torres Strait Islander people have been involved in the research since inception to ensure the research is respectful of Aboriginal cultural values and beliefs and responsive to community priorities. The advisory group have advocated for the research, facilitated community liaison, provided advice on study design, and contributed to interpreting the data through discussing the key themes and example quotes. The research question was co-created between the research team and the advisory group. Patients were not involved in this phase of the study.

Data collection

Data collection was in two parts. Part 1 involved a survey considering demographic details of the GP registrars and select questions from an Australian cultural capability self-assessment tool measuring respect, communication, safety and quality, reflection and advocacy (18) and an Australian self-assessment tool measuring attitude change (19). When queries in these surveys overlapped, the attitude change measurement questions were preferentially used due to its previous use with medical students, as opposed to mostly nursing students. The survey was followed by semi-structured interviews with GP registrars to explore their perception of consultations with Aboriginal and Torres Strait Islander patients. At the end of the semi-structured interview, the interviewer requested participants use a 5-scale Likert score to rate the importance of elements traditionally associated with culturally safe care (eye contact, silence, the use of traditional language, inclusion of spirituality in a consultation, and the importance of including family/elders in the consultation (17).

Data analysis:

Survey data was descriptively analysed to both characterise the cases and provide contextual data for assisting in interpreting the interview data. Transcripts were studied using a content analysis (20) approach using theory-driven codes derived from the AHPRA definition of cultural safety (and emerging data-driven codes) (16). Codes included ongoing critical reflection, knowledge (language, connection to country, importance of family, spirituality, colonisation), skills, attitudes, practicing behaviors (communication strategy, consultation model), and free of racism (culturally unsafe care, understanding of healthcare initiatives to improve patient outcomes, patient choice of GP). The survey results are reported alongside the interview data to add strength and meaning to registrar comments or to compare with interview results.

Reflexivity:

The principal investigator Author (A) 1 is an experienced GP academic working in an Aboriginal Medical Service. A2 is a GP clinician researcher, A3 a clinician researcher, A4 an Aboriginal cultural educator for the GPRTO, A5 and A6 are clinical academics, and the latter is director of the GPRTO. A7 is an Aboriginal academic from Kunja Nations. The research assistant is an evaluation coordinator with the GPRTO and conducted registrar interviews.

Results

Participant characteristics

A total of 26 registrars responded to the recruitment email and completed the survey. Of these, 16 registrars also completed an interview. All 26 survey respondents agreed to be interviewed, but practicalities of interview organisation resulted in only 16 registrars, including two registrars who self-identified as Aboriginal and Torres Strait Islander, being interviewed. Most registrars were less than 34 years old, had graduated from an Australian university and had limited experience in Aboriginal and Torres Strait Islander health.

A total of 618 minutes of audio-recording was analysed. The median length of interviews was 33.4 minutes with the longest interview 95 minutes and the shortest 18 minutes.

We report the data under three major content themes including (1) how registrars structure their consultation, (2) how registrars demonstrate cultural safety, and (3) registrars' attitude towards Aboriginal and Torres Strait Islander peoples.

Theme 1: Structure of the consultation

Two subthemes were identified which describe how most registrars do not identify any distinctive features in their consultations with Aboriginal and Torres Strait Islander patients.

1.1 Alignment with patient centred care

Registrars did not specifically identify any theoretical models that they used to structure a consultation (for example, the Calvary-Cambridge model). Registrars described characteristics of consultations that aligned with patient-centred care and that emphasised a holistic approach with continuity of care (table 1).

1.2 Similar approach for all patients whether Indigenous or non-Indigenous

Despite recognising a need to close the gap on health outcomes for Aboriginal and Torres Strait Islander peoples and wanting to do things differently, most registrars adopted a generic approach to all consultations. Nearly half of the registrars indicated that they would treat Aboriginal and Torres Strait Islander patients the same as other patients (Figure 1) and had a similar approach to consultations for all patients, apart from additional health promotion and screening (table 1). It was unclear from these statements if registrars were implying that patients have the right to equitable and non-racist healthcare or that the delivery of healthcare should be homogeneous. In addition, registrars provided limited examples of how a patient's Aboriginal and Torres Strait Islander identity or knowing about colonisation, influenced their clinical practice. Despite wanting to treat all patients the same, most registrars considered a Western medical model of health care did not meet the needs of Aboriginal and Torres Strait Islander patients (Figure 1).

One registrar had a very narrow application of cultural safety describing it as a discrete component of the consultation and that cultural safety was determined within the first stages of a consultation.

> And that the cultural safety stuff is actually almost like a barrier that you need to get over. And once you get that out of the way the interaction in the consult becomes like any other interaction and consult with any other patient... (6389)

Registrars did not appear to have a structured approach to considering elements of wellbeing such as connection to community, family and kinship, mind and emotions, or spirituality.

Table 1: Structure of a consultation with Aboriginal and Torres Strait Islander patients as described by GP registrars.

Subtheme	Participant quotes
Structure of the consultation	
Alignment with patient-centred care	I think what working in Aboriginal and Torres Strait Islander health has taught me as well is that to appreciate the person within the context of them, their family and their community and their culture. And I think the fact that I'm open to that makes it a little bit easier for Aboriginal and Torres Strait Islander people to come to me. (1131)
Similar approach for all patients whether Indigenous or non-Indigenous	I usually do very much the same thing as I do with other people. But I think in terms of certain things, as in screening or other things that are slightly different for Aboriginal population versus the non-Aboriginal population, I kind of just do a blanket statement and say, “This is because of your background that you identify yourself as [Aboriginal and Torres Strait Islander] there will be this and this, this, this, that needs to be done just for your health sake…I do offer them health assessments and stuff like that…So I think that's something different because you're eligible for those things. But I don't really treat them any different really. I see them as the same. (6434)

Theme 2: Demonstration of cultural safety

Two subthemes were identified which describe communication skills and the GP environment.

2.1 Communication skills (non-verbal and verbal)

Registrars described demonstrating culturally safe care through focussing on communication skills with Aboriginal and Torres Strait Islander patients and considered communication skills equally as important as clinical skills (Figure 1).

Silence in a consultation was rated as important (average 3.875/5 on the Likert scale), but not considered distinctive to consultations with Aboriginal and Torres Strait Islander patients. Registrars were divided on the importance of eye contact with patients and variably described approaches to determining the appropriateness of eye contact for individual patients (Table 2). Appropriate eye contact with patients was clearly a concern for registrars with several describing an “eye-dance” when trying to gauge from social cues if the patient was comfortable with eye-contact. Registrars also reflected on how eye contact, or lack of eye contact, made them feel: rather than how the patient felt.

Registrars described the importance of other non-verbal communication skills such as listening, body position/stance, and physical touch. One registrar mentioned physical touch as part of culturally safe care, reflecting “it was a good thing” without considering how the patient felt about this contact (Table 2). Registrars were sometimes aware of power differentials and attempted to address this by using wearing casual clothing, and adopting a body posture that did not create a physical height gradient (Table 2).

Registrars frequently spoke about use of informal language and simplifying speech for patients (including slang and humour), avoiding jargon, mirroring a patient’s speech, and questioning patients' understanding Table 2). Many registrars described a conversational or yarning approach to a consultation, implying a two-way equal exchange, but frequently used language suggesting dominance or paternalism such as "talking to them", and "where I can express myself".

Registrars described enquiring about connection to country and/or family to build rapport with patients (Table 2). Registrars appeared to assume this was a safe question even when patients described loss of connection to family and country. Registrars also described asking "Are you of Aboriginal or Torres Strait Islander origin?" as both a barrier and facilitator to creating rapport with patients. Within Australian general practice it is recommended that this question is asked at every presentation (21). Some registrars were concerned about how not to be racist in asking patients to identify their ethnicity or when applying an epidemiological approach to the consultation. Other registrars assumed the question was safe or facilitated patient safety (Table 2). Registrars grappled differently with the concept that identification as an Aboriginal and Torres Strait Islander person may be fluid (Table 2) and at times patients may choose not to identify. Racism, and lack of recognition that fair-skinned people may identify as Aboriginal and Torres Strait Islander, was also demonstrated by a registrar who described a culturally unsafe approach to consultations by interrupting "white people" when they are taking a narrative or yarning approach within the consultation. Other registrars assumed that because the patient appeared to be Caucasian and/or of higher socio-economic status that they would not be affected by colonial failings.

Table 2: Communication skills used by registrars when consulting with Indigenous patients.

Subtheme	Participant quotes
Eye contact	…if I have a patient who I've seen from the chart is Indigenous, I normally start off avoiding eye contact initially and then just kind of see what they're doing to then see, is this person also doing it [avoiding eye contact]? And then try and

	feel out early on, does it seem like they're looking away or uncomfortable? Or if I look them in the eyes, do they appreciate that and prefer that?" (4091)
Other non-verbal communication skills	I actually found that touch was actually a good thing: sitting there and like actually holding their hand (6389). ... I try and sit down if I can...So there isn't... [a feeling] I'm standing over them... And a lot of body language issues like not being necessarily front on, it can be kind of confrontational in the same way as the eye contact, sitting rather than standing over them. (4091)
Use of informal language (including slang and humour)	I guess the biggest thing I try to do is not create like a authority type situation where I am above them by any means. Just because I'm a doctor, I try to be as casual as I can. I want them to treat me like somebody ...that they're just talking to casually and that they would want to just tell everything to...So, I guess appropriate understanding, common slang terms and then appropriate words to use in return... So, things like when they say that, oh, "This is deadly". (2601)
Enquiry about connection to country	One thing I learned after our training as well actually is that often when we've got some time, especially after doing our consult, it is just to ask a little bit about, you know, where are you from and like how long have you been there? Is that is that where your family is from or just try to get a bit more of an understanding? I have found that when I've asked those questions, I found out a lot of surprising things... (2601)
Use of the question, "Are you of Aboriginal or Torres Strait	I know there's one time where it was a new patient to me, and I was just filling up the system for the patient's profile. And I think rather than saying, "Do you identify yourself as?", you know, in a more politically correct way, I kind of just said, oh, "Are you Aboriginal?" And then they're like, "Yeah, well, I can be, can't I?"

Islander origin?”	And I was like, “Oh, no, I didn't mean like that, you know?” Yeah. So, I think it just slipped too quickly versus me processing it and using it the more PC [politically correct] way of asking. Yeah. So, I had to quickly say to them, “No, no, no, I didn't mean that. I just meant I just need to fill up your information. Doesn’t matter who you identify, what you identify as, it’s just with the Aboriginal status, you do get a lot more perks or a lot more things that we need to look into. (6434). But on the flip side, I'm blatantly asking, "Are you a particular race?", so that I could treat you accordingly. So, I'm very conflicted with that sometimes. Or a young child that comes in asking them like, have you had those extra vaccines because you're at risk of this and this. So, it's so, I, I try to say I'm trying to be professional, but I can see how some people can see that as offensive. It's like, "Oh, how dare you ask me that, so I'm lesser so I need more vaccines or need...?" (3270) I don't tend to ask [about identity] and that's because it's already collected. So, I already know from the information. If it's not written there, it often comes up though, if I'm having to do additional paperwork, then I say, “I just I would like to check. Do you identify as Aboriginal or Torres Strait Islander?” …And, so, I often don't necessarily ask them, particularly in the consult every time. (7400)

2.2 GP environment (safe and welcoming environment, appointment times, family, privacy, and spirituality)

Several registrars described creating a safe welcoming environment for Aboriginal and Torres Strait Islander patients through displaying Aboriginal flags, maps, artwork, acknowledgements to country and employment of Aboriginal and Torres Strait Islander staff within the practice. An Aboriginal and Torres Strait Islander registrar spoke of the physical environment being less important than registrar's attitude and communication skills in the delivery of culturally safe care (9304). Flexible and longer appointment times were seen as an important way of improving access to care (Table 3). About one third of registrars indicated that the presence of two or more family members in a consultation is disruptive and should be limited or restricted (Figure 1). However, in interviews registrars recognised the importance of family within consultations. All registrars agreed (n=6) or strongly agreed (n=19) that the quality of patient care could be compromised if a GP was oblivious to the family's cultural attributes and values. However, as mentioned previously, registrars were able to give limited examples of how this occurs in practice.

Other factors registrars considered important in demonstrating cultural safety included the provision of culturally tailored patient education, culturally appropriate referrals, patient consent, confidentiality, and privacy (Table 3). Registrars had divergent views on the importance of being considerate of spirituality in a consultation. An Aboriginal and Torres Strait Islander registrar spoke of considering spirituality as part of providing holistic care (Table 3).

Table 3: Adapting the GP environment when consulting with Aboriginal and Torres Strait Islander patients.

Subtheme	Participant quote
Safe welcoming environment	I don't work in a practice where there's Aboriginal posters everywhere. I work in a practice where it's not very welcoming at all and that's something that I will change. But the aesthetics are secondary to actually being open and honest in your communication and accepting people for who they are on their journey and helping them to progress their health journey in a way that it's just enough for them. (9304)

Inclusion of family	I always offer for a family member to be present because I think as much as support as I can give, often times family members [can] provide way more emotional support. (6278)
Privacy	But privacy is really number one…. And I actually found in a way, in a weird way, not having an Indigenous background sometimes made them prefer me as opposed to go there because there was the workers who were the aunties or the cousins or the all in the community and they were they didn't want word getting out about certain things. (6389)
Spirituality	Spirituality isn't something I would identify with Aboriginal culture so much (7216). I think it's very important because that's part of their I guess their identity and the medical perspective is also important to consider. Like, not like we always talk in med school spirituality doesn't mean psychosis and hallucinations (6278). It [spirituality] underpins attitudes to health, attitudes to healing and health for Aboriginal people is a holistic thing. It's not just I hurt my toe, or I've got a chest pain, it's got to do with everything else that's going on in their life. And that includes spirituality. (9304)

Theme 3: Attitude

Registrars described a variety of attitudes that they considered to be important in consultations with Aboriginal and Torres Strait Islander patients, particularly being non-judgemental, open-minded, kind, and respectful (Table 4).

Registrars thought they were demonstrating respect when acknowledging a person's Indigenous status, being considerate of local customs, providing patient-centred care, referral to culturally appropriate services, treating Aboriginal and Torres Strait Islander patients the same as other patients, and having an open-minded and non-judgemental attitude. Registrars minimised potential power differentials by expressing the similarities they have with Aboriginal and Torres Strait Islander patients. This included similar family structures, being darker skinned or also identifying as Aboriginal and Torres Strait Islander.

Registrars described their Aboriginal and Torres Strait Islander patients in a variety of ways and frequently referred to Aboriginal and Torres Strait Islander patients as being like themselves or not different to other patients. However, many of the descriptors "othered" Aboriginal and Torres Strait Islander people, were from a deficit perspective, and at times appeared to be unconsciously racist. Similarly, describing initiatives to achieve health equity as "perks" further marginalised the disadvantaged. A few registrars described treating Aboriginal and Torres Strait Islander patients using the moral rule of "treat others the way you want to be treated". Registrars regularly referred to Aboriginal and Torres Strait patients "as human" or "like a human" (Table 4). Negative descriptors of Aboriginal and Torres Strait Islander patients were commonly used including disadvantage, dysfunction, chronic disease sufferers, substance abusers, non-compliant, swearing, and low levels of literacy. Positive descriptors were around attitude and personality (genuine, kind, humorous, honest, polite, understanding, trusting, forgiving, patient). Some registrars described the diversity of their patients (Table 4) and compared how some Aboriginal and Torres Strait Islander patients are higher income earners than medical professionals (Table 4).

Table 4: GP registrars' attitude to Aboriginal and Torres Strait Islander patients

Subtheme	Participant quotes
Non-judgemental, open-minded, kind, and respectful.	I don't think patients expect us to be culturally aware of everything and every possible culture. But I think as long as we're willing to learn, I think patients appreciate that. And I think if you're being honest with patients like 'please feel free to correct me if I'm wrong about your culture or if you feel like I'm saying anything offensive.' I would be happy to correct my words, and I think people would appreciate that. If you're just being honest, if you don't know, then you don't know. (6278) I think the biggest tips and tricks I would say is I guess the simple golden rule is to treat everyone like you want to be treated. (2797)
Expressing their similarities to Aboriginal and Torres Strait Islander patients	So that could be something culturally as well. When I have spoken to them, we also have a very strong cultural framework in which the families are very united. We also call our elders, uncle, and aunties, and they also call everyone uncle and aunties. So, when I have discussed, they have found that this is more closer to what their culture is. (1111)
"Like a human"	I think, treating them like a human being. That's a big thing. I think that no two patients will be the same regardless of their background. And only I guess, only if you absolutely have to ask, you know, about certain things in their history, then then you can bring up the subject. But the biggest thing is that they're not a number. They're a person just like every other person in the world. (3270)

	I mean, treating them as human. Yeah, I think it's awareness of those communication issues or different communication norms, awareness of history and how that could impact and shape the consult. Letting them run it, making sure I try and avoid as much paternalism as possible. I try and do that for all my patients, not just Aboriginal Australian ones. (4091) I think just be respectful and treat them the same as you would when you're treating non-Aboriginals or family or family friends like you don't treat them any different really, because they're also humans. (6434)
Diversity	Aboriginal Australians come...They're not just one homogenous group, there are all kinds of different people with all kinds of different life experiences, family experiences and cultural norms, which makes it such a diverse group to work with, I find. (4091)

Discussion

A general practice consultation that is culturally safe for Indigenous peoples remains a health goal for Australia and other countries as part of the efforts to address the ongoing disparity in health outcomes for Indigenous peoples (4). Historically, Aboriginal and Torres Strait Islander people have not been permitted to significantly contribute to the determination of cultural safety in healthcare. As such, understanding what characteristics define a culturally safe consultation, particularly as determined by Aboriginal and Torres Strait Islander peoples, is an evolving and developing area of research and discussion. Cultural safety is a complex notion and understanding how registrars view their clinical practice can contribute to narrowing the gap between desired patient/community-defined culturally safe healthcare and the care which is delivered.

This study shows that amongst this small sample, GP registrars want to treat all patients the same and are conscious of not being racist in their practice. However, despite wanting to treat all patients the same, registrars detailed several contradictions to this philosophy. These included:

1. Registrars indicated in the survey that Western models of healthcare may not be suitable to meet the health needs of Aboriginal and Torres Strait Islander peoples but in the interviews did not describe utilising a different model of consultation for patients. Similarly, several registrars indicated in the interview the importance of family in Indigenous culture but in the survey reported that the presence of two or more family members in a consultation is disruptive and should be limited or restricted. Furthermore, it seemed registrars feared offending Aboriginal and Torres Strait Islander patients by asking questions related to their Aboriginality or making eye contact with them. This may indicate that registrars have an awareness of the impact of culture on a patient's health and wellbeing but are not equipped to adapt their consultation approach for distinctive population groups.

2. Registrars seemed to abide by the moral rule of "treat others the way you want to be treated" and failed to recognise that cultural safety should be determined by those being treated, that is, "treat others the way they want to be treated". This indicates the critical unlearning that needs to occur to progress culturally safe treatment and care.

3. Registrars described seemingly desirable attitudes of being non-judgemental, open-minded, kind, and respectful but this was frequently discordant with registrars' choice of language when describing Aboriginal and Torres Strait Islander patients. Registrars also did not indicate in interviews the importance of self-reflection or critically examining their own bias, values, and beliefs. Some registrars were very conscious of practising medicine in a way that was not discriminatory or racist but were unconsciously reinforcing structural racism and internalized racial superiority through a deficit and "othering" approach. Registrars may have been trying to be use the word "humans" as inclusive language. However, use of the metaphor and simile to state "treating them like/as a human" implies that registrars are treating Aboriginal and Torres Strait Islander patients as subhuman. Registrars also recognised power imbalances and tried to address these in practice by simplifying language and reducing height imbalance but at the same time minimised differences and power differential by focussing on their similarities with Aboriginal and Torres Strait Islander peoples.

This study suggests we need to develop a model of cultural safety training for GP consultations within the Australian context where cultural safety is defined by the Aboriginal and Torres Strait Islander community. Registrar transformative learning and unlearning needs to occur to shift attitudes and action to impact on the health and wellbeing of Aboriginal and Torres Strait Islander peoples. For example, there are many traditional teachings and folklore in Indigenous healthcare delivery in Australia that tend to homogenise a diverse population and reinforce stereotypes. These include aspects of practice such as avoiding eye contact, providing plenty of silence, and ensuring family are included in consultations. Changing or adapting this narrative and discerning the difference between what patients need and want, and how registrars deliver care, will shape healthcare education and training for registrars. In this study we did not aim to explore if Aboriginal and Torres Strait Islander GP registrars treat Indigenous and non-Indigenous patients the same. The

Aboriginal and Torres Strait Islander registrars drew on their lived experience when describing health care and their delivery of care.

This study is part of a larger research project that includes exploring a culturally safe consultation from the patient's perspective and how to assess cultural safety in a GP consultation (17). In developing this assessment, we need to consider a model of care where all patients are not treated the same but distinctively different considering their historical, political, and social determinants of health and their individual body, mind and emotions, family and kinship, community, culture, country and spirituality and ancestors (12).

Strengths and Limitations:

This mixed-methods study allowed comparison of survey and interview data to better understand registrars and how they considered Indigenous health. The in-depth qualitative data collected provides insight to this sample's perceptions of cultural safety. At 16 interviews, analysis suggested that no new insights were being generated and thematic saturation had been reached. The sixteen registrars who were interviewed were from diverse backgrounds including Aboriginal and Torres Strait Islander doctors and international medical graduates. The small sample of GP registrars were in one Australian state across a broad geographic region covering many different traditional Aboriginal and Torres Strait Islander nations.

This study relied on registrar self-assessment and self-reporting and did not attempt to measure registrar insight. Voluntary or self-selection response bias also suggests participants with an interest in Indigenous health and cultural safety were more likely to participate in the study. As such, non-participating registrars are likely to have a greater deficit in understanding culturally safe care than participating registrars. Many registrars had limited experience with Aboriginal and Torres Strait Islander patients and as such this dichotomy may reflect social desirability bias (what registrars considered would be favourably viewed by the researchers and the Aboriginal and Torres Strait Islander population) and their academic learnings throughout their medical school and university training, rather than actual belief and clinical practice. This may also reflect that registrars have difficulty translating cultural safety training into practice and instead revert to familiar practice. Furthermore, the practicing behaviour of participating registrars may be quite different to what is reported, as demonstrated by the adapted Miller's pyramid of clinical competency (doesn't know/needs to know / unknown through to does and professional identity) and is worthy of further research (8). We also query whether Aboriginal and Torres Strait Islander registrars adapt different styles when consulting with Indigenous or non-Indigenous patients.

Conclusion

This study suggests that overall, GP registrars want do improve the health of Aboriginal and Torres Strait Islander patients, but do not want their consultations with Aboriginal and Torres Strait Islander patients to be distinctive. Registrars appeared to approach all consultations in a similar manner using predominantly patient-centred care principles. Given the importance of a culturally safe consultation, it is important for us to consider how to increasingly transform these learners and teach cultural safety in this context.

Declarations

Ethics approval and consent to participate:

The James Cook University Human Research Ethics Committee approved this study (H8296) following review by Aboriginal and Torres Strait Ethics Advisors in accordance with the National Health and Medical Research Council guidelines.

Consent for publication: Not applicable.

Availability of data and materials: The datasets analysed during the current study are not publicly available due to participants being potentially identifiable from the small dataset but are available from the corresponding author on reasonable request.

Competing interests: Nil

Funding: This project has received funding through an Australian College of Rural and Remote Medicine: 2022 Education Research Grant.

Authors' contributions:

KB conceptualized and led the design of the project, analysed, and interpreted the registrar data, and was the major contributor in writing the manuscript.

HW, RE, HN, TS, LM and RW contributed to co-design of the project, data analysis and drafting and revision of the manuscript.

All authors approved the manuscript for publication.

Acknowledgements: Kerrilee Gow who managed the project and undertook data collection, the Community advisory panel for supporting and overseeing the research project.

References

1. Royal Australian College of General Practitioners. RACGP Educational framework. Melbourne: RACGP; 2020 [Available from: https://www.racgp.org.au/education/registrars/fellowship-pathways/racgp-educational-framework/acknowledgments.

2. Delaney L. Patient-centred care as a approach to improving health care in Australia. Collegian. 2018; 25:119-23.

3. Australian Commission on Safety and Quality in Health Care. Patient-centred care: Improving quality and safety through partnerships with patients and consumers. Sydney: 2011. p. 104.

4. Ahpra & National Boards. The National Scheme’s Aboriginal and Torres Strait Islander health and cultural safety strategy 2020-2025. Canberra: Ahpra and National Boards; 2020.

5. Morgan S, Chan M, Starling C. Starting off in general practice - consultation skill tips for new GP registrars. AFP. 2014; 43(9):645-8.

6. Silverman J, Kurtz S, Draper J. Skills for Communicating with Patients. Radcliffe Medical Press (Oxford). 1998.

7. Neighbour R. The inner consultation: how to develop an effective and intuitive consulting style. 2nd ed. Oxford: Radcliffe Medical Press; 2004.

8. Pendelton D, Schofield T, Havelock P. The consultation: an approach to teaching and learning. Oxford: Oxford University Press; 1984.

9. Murtagh J, Rosenblatt J, Murtagh C, Coleman J. Murtagh general practice. 8th ed. Australia: McGraw Hill; 2021.

10. Pitama S, Bennett S, Waitoki W, Haitana T, Valentine H, Pahina J, et al. A proposed Hauora Māori clinical guide for psychologists: using the Hui Process and Meihana Model in clinical assessment and formulation. New Zeal J Psychol. 2017;46(3):7-19.

11. McKivett A, Paul D, Hudson N. Healing conversations: developing a practical framework for clinical communication between Aboriginal communities and healthcare practitioners. J Immigr Minor Health. 2019;21(3):596-605.

12. Gee G, Dudgeon P, Schultz C, Hart A, Kelly K. Social and emotional wellbeing and mental health: an Aboriginal perspective. In: Dudgeon P, Milroy M, R W, editors. National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017-2023. Revised ed. Canberra: Department of Prime Minister and Cabinet: Commonwealth of Australia; 2017. p. 55.

13. Grant J, Parry Y, Guerin P. An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. Aust N Z J Public Health. 2013;37(3):250-6.

14. Paul D, Hill S, Ewen S. Revealing the (in)competency of "cultural competency" in medical education. AlterNative. 2012;8(3).

15. Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee. Cultural respect framework 2016-2026. Adelaide: Australian Health Ministers' Advisory Council; 2016.

16. AHPRA & National Boards. A consistent baseline definition of cultural safety for the National Scheme. Canberra2019.

17. Brumpton K, Ward R, Evans R, Neill H, Woodall H, McArthur L, et al. Assessing cultural safety in general practice consultations for Indigenous patients: protocol for a mixed methods sequential embedded design study. BMC Medical Education. 2023;23(1):306.

18. West R, Wrigley S, Mills K, Taylor K, Rowland D, Creedy D. Development of a First Peoples-led cultural capability measurement tool: a pilot study with midwifery students. Women Birth. 2017; 30(3):236-44.

19. Ryder C, MacKean T, Ullah S, Burton H, Halls H, McDermott D, et al. Development and validation of a questionnaire to measure attitude change in health professionals after completion of an Aboriginal health and cultural safety training programme. Australian Journal of Indigenous Education. 2019;48(1):24-38.

20. Erlingsson C, Brysiewicz P. A hands-on guide to doing content analysis. African Journal of Emergency Medicine. 2017;7(3):93-9.

21. Royal Australian College of General Practitioners. Standards for general practices. 5th edn. East Melbourne: RACGP; 2020.

Figure Legend:

Figure 1 – Cultural capability measurement and attitude as self-reported by GP registrars.

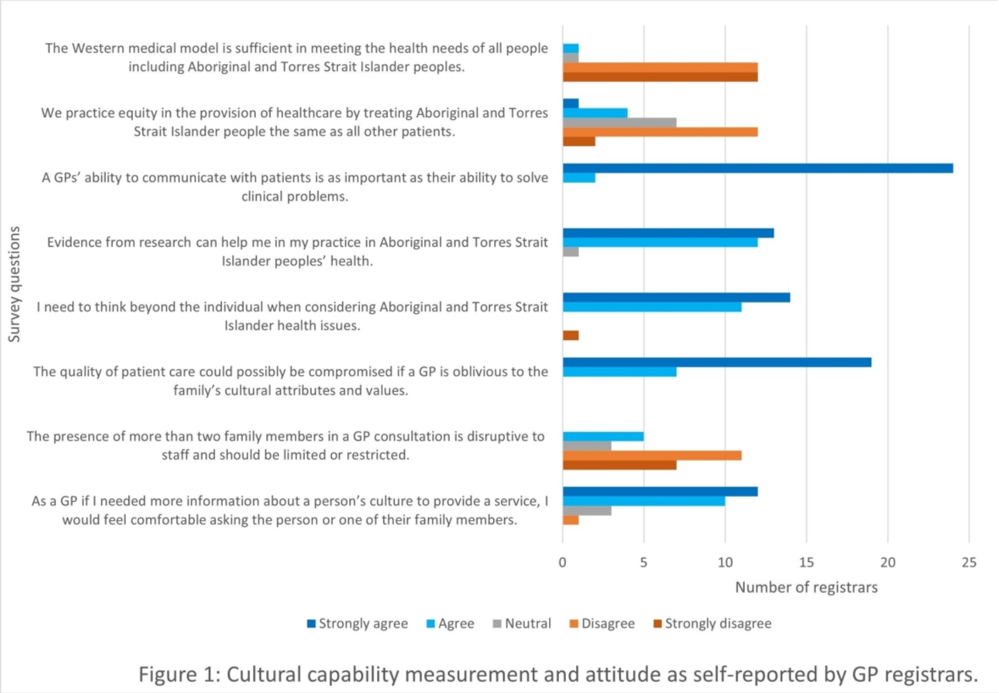


Figure 1: Cultural capability measurement and attitude as self-reported by GP registrars.

208x145mm (300 x 300 DPI)

Brumpton *et al. BMC Medical Education (2023) 23:306*
https://doi.org/10.1186/s12909-023-04249-6

BMC Medical Education

STUDY PROTOCOL **Open Access**

Assessing cultural safety in general practice consultations for Indigenous patients: protocol for a mixed methods sequential embedded design study

Kay Brumpton[1*], Raelene Ward[2], Rebecca Evans[3], Henry Neill[3], Hannah Woodall[1], Lawrie McArthur[3] and Tarun Sen Gupta[3]

Abstract

Background Assessment of cultural safety in general practice consultations for Indigenous patients is a complex notion. Design and development of any assessment tool needs to be cognizant that cultural safety is determined by Indigenous peoples and incorporates defined components of cultural safety and current educational theory. Consideration of how social, historical, and political determinants of health and well-being impact upon the cultural safety of a consultation is also important. Given this complexity, we assume that no single method of assessment will be adequate to determine if general practice (GP) registrars are demonstrating or delivering culturally safe care. As such, we propose that development and assessment of cultural safety can be conceptualised using a model that considers these variables. From this, we aim to develop a tool to assess whether GP registrars are conducting a culturally safe consultation, where cultural safety is determined by Aboriginal and Torres Strait Islander peoples.

Methods This protocol will be situated in a pragmatic philosophical position to explore cultural safety primarily from the Australian Aboriginal and Torres Strait Islander patients' perspective with triangulation and validation of findings with the GP and GP registrar perspective, the Aboriginal and Torres Strait Islander community, and the medical education community. The study will integrate both quantitative and qualitative data through three sequential phases. Data collection will be through survey, semi-structured interviews, an adapted nominal group technique, and a Delphi questionnaire. We aim to recruit approximately 40 patient and 20 GP participants for interviews, conduct one to five nominal groups (seven to 35 participants) and recruit fifteen participants for the Delphi process. Data will be analysed through a content analysis approach to identify components of an assessment of cultural safety for GP registrars.

Discussion This study will be one of the first to explore how cultural safety, as determined by Indigenous peoples, can be assessed in general practice consultations. This protocol is shared to stimulate awareness and discussion around this significant issue and prompt other studies in this area.

Keywords Cultural safety, General practice, Registrars, Indigenous, Assessment

---

*Correspondence:
Kay Brumpton
k.brumpton@ruralmeded.org.au
Full list of author information is available at the end of the article

Background

Much has been written about the concept of cultural safety and its importance in the improvement of health care delivery for racial minority groups, particularly for Indigenous peoples affected by colonisation [1, 2]. Ramsden, a Māori nurse, who first proposed the concept of cultural safety in healthcare, articulated a three-step progression in the development of cultural safety from cultural awareness to sensitivity, and safety [3]. More recently, development of cultural safety has been described as a continuous circular model from awareness (cognizant of differences) to sensitivity (understanding and respecting these differences), competence (responding to own bias and developing skills), and safety [4]. Others, including Paul et al. [5], argue however that any discussion on cultural safety that focuses on differences and disparity between cultures, rather than reflection on practice, should be challenged.

Indeed, cultural safety is a complex notion and lack of a consistent definition has somewhat stymied the progression of evidence in this space [6]. Currently, whilst the concept of cultural safety or similar [7, 8] is embedded deeply in health and health education policy and frameworks [9–13] there is minimal evidence for the effectiveness of cultural safety training in improving patient health outcomes [14–18]. The use of a consistent definition for cultural safety provides an opportunity to provide clarity around the terminology used and address the paucity of evidence related to cultural safety [14–18]. Australia has attempted to address this by releasing a consensus statement, agreed upon by the Australian Health Practitioner Regulation Agency (AHPRA), regarding Australia's colonised Indigenous population of Aboriginal and Torres Strait Islander peoples [19]:

> *"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Cuturally safe practise is ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism" [19].*

According to the Australian Bureau of Statistics, Australian Aboriginal and Torres Strait Islander people represent approximately 3.2 percent of the Australian population [20] and have a burden of disease 2.3 times that of non-Indigenous Australians [21]. Aboriginal and Torres Strait Islander peoples' strength and resilience, as one of the oldest world cultures, is impacted by the colonisation of Australia. Colonisation is described by Aboriginal health academic McKivett as: "the colliding of two worlds and the meeting of different systems of knowledges and beliefs" [8] p596. Colonisation, along with social determinants of health, continue to affect the health and wellbeing of Aboriginal and Torres Strait Islander peoples today. As such, Aboriginal and Torres Strait Islander people, again as described by McKivett et al., "Are striving to maintain collective values, traditions and beliefs whilst also coping with high burdens of chronic disease, reduced life expectancies and the impacts of grief, loss and trauma" (p596).

In Australia, AHPRA worked with other significant stakeholders to develop a national Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy (2020–2025) which casts a vision that patient safety, including both clinical and cultural safety, is the expected standard of care for Aboriginal and Torres Strait Islander peoples and that this standard of safety is defined by Aboriginal and Torres Strait Islander peoples [22]. The National Strategy also considers that developing a culturally safe general practice workforce is a key strategy in improving health outcomes for Aboriginal and Torres Strait Islander peoples [22]. Delivery of culturally safe health care can improve quality of health care [23] and should, by inference, improve disparities in the life expectancy and morbidity patterns experienced by Indigenous peoples [24, 25]. For most patients in the developed world, a General Practitioner (GP) is the first point of contact when accessing healthcare and is the most persistent relationship for a patient within the health system [26]. As such, a culturally safe GP can play a crucial role to closing the gap in health outcomes for Indigenous peoples [27]. We argue that development of cultural safety in GP registrars is a priority for general practice training [28]. Logically, the development of cultural safety should occur early in postgraduate training as reflected by the recent inclusion of the AHPRA definition of cultural safety into the Australian GP curricula by the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) [29, 30]. The AHPRA consensus statement, along with recent educational developments (for example, revision of Australian Medical Council graduate outcomes [31], and assessment changes by the RACGP [28]), provides opportunity to reassess the health professional educational response to teaching and assessment of cultural safety.

Understanding how GPs and GP registrars define, develop, and perceive cultural safety could assist identification of areas where cultural safety is lacking or needs improvement. A 2016 integrative review, conducted prior to release of the AHPRA definition, demonstrated a significant gap in evidence on how cultural safety is developed by GPs when consulting with Aboriginal and Torres Strait Islander peoples [32]. The literature cited suggests a lack of understanding regarding cultural safety development in GP registrars, or how cultural safety training influences GP registrar behaviour and consulting practices. Furthermore, as assessment is considered to drive learning, consideration of how cultural safety can be assessed, in a formative and summative manner, is required. These assessments require a clear definition and description of culturally safe practice, which must be determined by Aboriginal and Torres Islander people and communities themselves. We are not aware of any assessment tools of consultation skills based on community-derived definitions.

Given the complexity of cultural safety, we assume that no single method of assessment will be adequate to determine where health professional learners sit on a spectrum from racist, through to demonstrating culturally safe care. Similarly, we assume that no single model of assessment or educational theory will incorporate this intricacy. As such, we propose that development and assessment of cultural safety can be conceptualised using a model that considers and, to some extent, aligns with: Miller's pyramid (a commonly used framework for the assessment of clinical skills/performance/competence) [33], the AHPRA definition of cultural safety [19], the continuum of cultural safety [3, 4], Aboriginal ways of knowing, doing, and being [34], transformative learning theory [35], and Gee et al.'s model of social and emotional wellbeing that incorporates historical, social and political determinants of health and wellbeing [26] (Fig. 1).

To explain this model further we start with Miller's pyramid (the blue triangle in Fig. 1). We use the example of training for an Australian GP fellowship. General practice training in Australia can currently be undertaken through one of five different pathways including the Australian General Practice Training (AGPT) program, Remote Vocational Training Scheme, Rural Generalist, Independent pathway and the General Practice Experience Pathway [36]. Fellowship can be achieved through two colleges, RACGP or ACRRM. RACGP registrars typically train for two to three years in general practice before completing a series of exams, including two written papers – "knows and knows how" and a clinical competency exam – "shows"—where at least one out of nine stations relate to an Australian Aboriginal and Torres Strait Islander patient with the same marking rubric used for all cases in the exam. RACGP registrars are currently not assessed summatively in the workplace in performance integrated practice ("does") [37]. In contrast, ACRRM registrars normally complete an additional training year when compared to RACGP registrars [38]. Their assessment includes direct observation of consultations "does" (referred to as mini-CEX) and multi-source feedback (MSF). A registrar is not required to include Australian Aboriginal and Torres Strait Islander patients in this process [38]. Summatively, a Structured Assessment using Multiple Patient Scenarios (best described as a hybrid viva-voce and objective structured clinical examination) is used and will typically involve at least one scenario with the candidate doing outreach clinics to a remote Australian Aboriginal community [38]. These assessments have not been validated with Australian Aboriginal and Torres Strait Islander patients [39, 40]. Recent authors have also proposed an additional layer to Miller's pyramid labelled "is", reflecting the concept of professional identity formation [41] and in the case of cultural safety, encapsulating ongoing critical reflection. In addition, we propose a further layer at the base of Miller's pyramid to reflect cultural incapacity or unconscious incompetence [42] as some health professional learners are not aware of their culturally unsafe stance.

Furthermore, using Miller's pyramid also allows us to demonstrate where terminology regarding cultural safety, or similar, align and ideally minimise confusion (orange triangle in Fig. 1). For example, cultural safety is the "is" and "doing" of Miller's pyramid whilst cultural competency is the "showing how". We also invert the pyramid for cultural safety terminology reflecting that we are wanting to place greater value on work-based assessment of cultural safety rather than static knowledge.

Additionally, within the model we overlay a triangle with the Australian AHPRA definition (the yellow triangle in Fig. 1). Within this framework the assessment of cultural safety should be considerate of the complex interplay between health professional learners and the components of the AHPRA definition [19]. The model also illustrates the importance of development and assessment of cultural safety being embedded in Aboriginal ways (the red triangles in Fig. 1). As such, Miller's pyramid, the AHPRA components of cultural safety, and the continuum of cultural safety are encapsulated within Martin and Mirraboopa's theoretical framework of Aboriginal ways of knowing (knowledge of history, culture, customs and beliefs), doing (skills and practicing behaviours) and being (critical reflection) [34].

Next, we nominate these components are founded upon a transformative learning ethos where the educational and assessment model aims, as described by Frenk et al. [35], to produce transformative leaders who are "enlightened change agents" (p 1952). Finally, the whole model is dependent on cultural safety being determined by Indigenous peoples and must consider the complexities of health and wellbeing including social, historical, and political determinants of these.

Our model provides a framework to both demonstrate and explore the complexity of cultural safety within a general practice consultation. The AHPRA consensus statement, is very broad, and whilst describing cultural

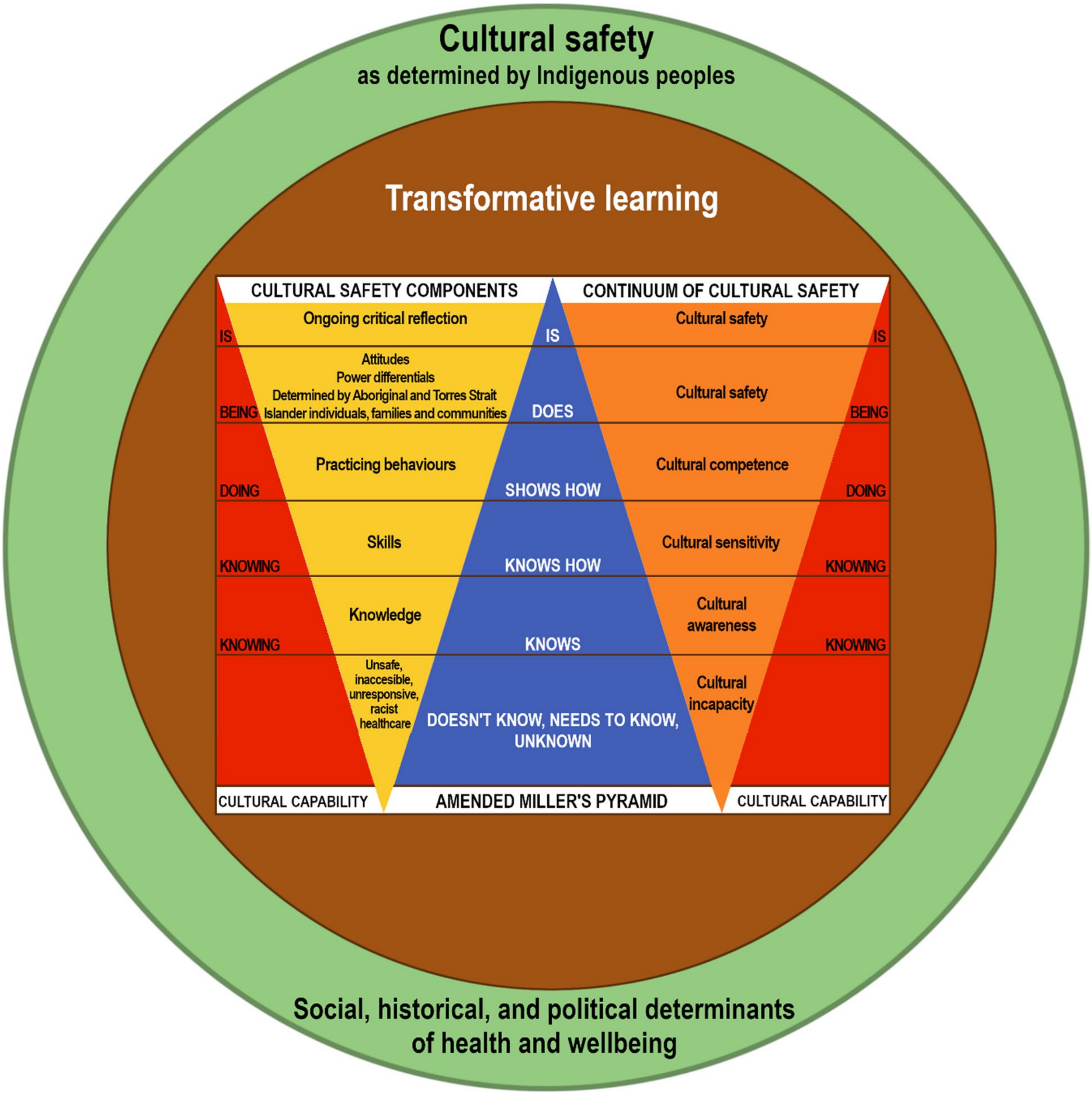


Fig. 1 Proposed model of cultural safety in general practice

safety, does not provide specific, or measurable attributes to guide registrar assessment. This risks registrar "knowing, doing and being" culturally safe care being ethereal unless further definition of what constitutes culturally safe care is forthcoming. As cultural safety must be determined by Aboriginal and Torres Strait Islander individuals, families and communities, these parameters must be derived and endorsed by the Aboriginal and Torres Strait Islander community. Ensuring Indigenous ownership adds additional complexity to the design and delivery of the assessment of cultural safety when the Aboriginal and Torres Strait Islander community, although viewed as a collectivist society, is a heterogenous society [43] and when it is normative for all patients to impose their individual bias on consultations [28].

In view of this complexity, we will present our research methodology including the development of data collection tools. We will use our proposed model to frame this research. The protocol outlined here will be used in several inter-related studies exploring the research question of "How can cultural safety, as determined by Aboriginal and Torres Strait Islander people, be assessed amongst GP trainees?" We aim to develop a tool to assess whether GP registrars are conducting a culturally safe consultation, where cultural safety is determined by Aboriginal and Torres Strait Islander peoples.

Methods

Methodological overview

This study will be situated in a pragmatic philosophical position to explore cultural safety primarily from the Aboriginal and Torres Strait Islander patients' perspective with triangulation and validation of findings with the GP and GP registrar perspective, the Aboriginal and Torres Strait Islander community, and the medical education community. Epistemologically, pragmatism is based on the premise of focussing on practical understandings of concrete, real-world problems and uses the best available methods to achieve this outcome [44]. This allows for integration of both quantitative and qualitative data to explore complex problems in need of a multi-dimensional approach [45].

Study design

This study is funded through an Australian government Medical Research Futures Fund Clinician Researchers grant, and an Australian College of Rural and Remote Medicine educational research grant. A mixed methods sequential embedded design approach [46] will be used to address the research question and sub-questions. This will be in three phases as indicated in Fig. 2.

This approach is chosen to generate data on the complex concept of cultural safety and allow for: (a) identification of culturally safe and unsafe care that can inform cultural safety training; (b) allow for triangulation of patient data with GP registrar and GP data; and (c) refinement and validation of the data with both Aboriginal and Torres Strait Islander peoples and medical education experts.

This study has been built upon the National Health and Medical Research Council guidelines for the ethical conduct of research with Aboriginal and Torres Strait Islander peoples [47]. It was therefore designed with the six values of ethical conduct in research at its core: namely spirit and integrity, responsibility, reciprocity, respect, equity, and cultural continuity [47]. The research was developed in response to a need determined by Aboriginal and Torres Strait Islander health workers and cultural mentors within a regional Aboriginal Medical Service (AMS) (hereafter referred to as the seed AMS) where KB is a practicing GP and RW the chairperson of the organisation. The team has

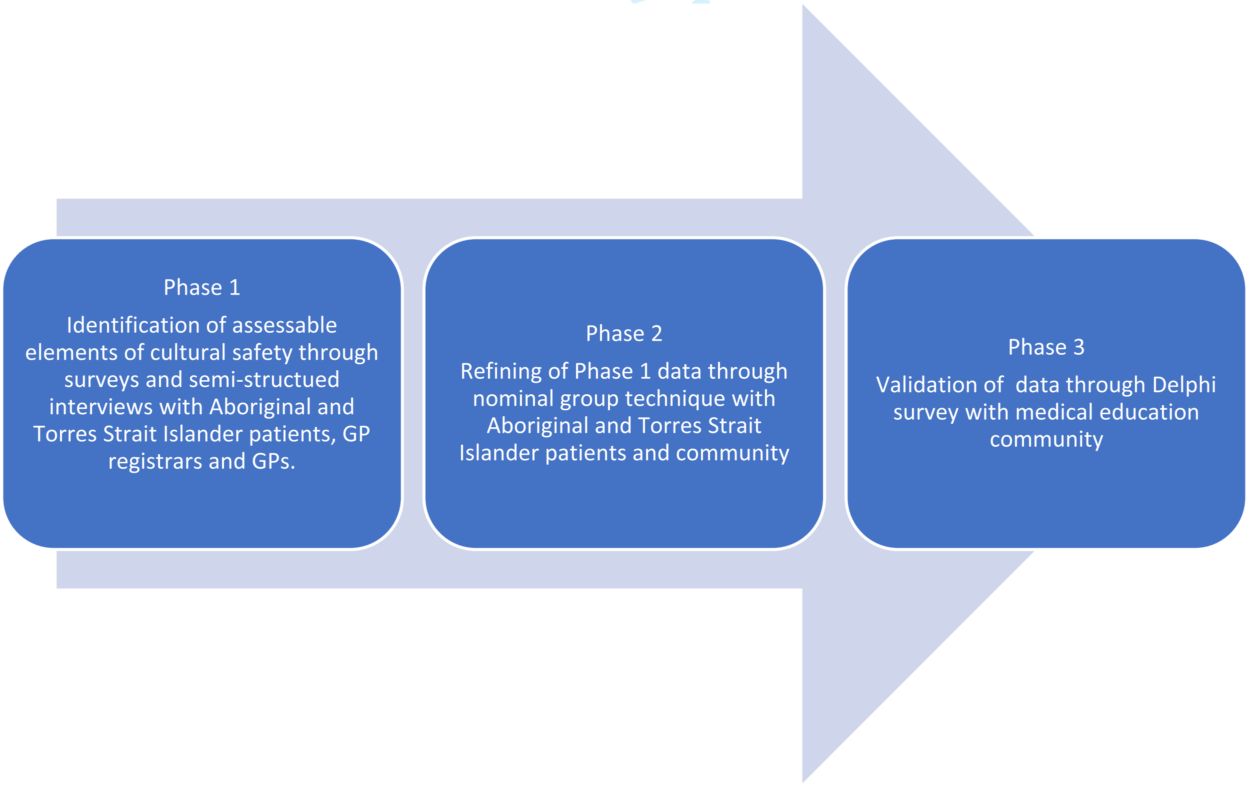


Fig. 2 Three phases of the research protocol

recruited an Indigenous expert panel to ensure these principles and local community protocols are adhered to and has involved health workers, cultural educators, cultural mentors, health advocates and Indigenous academics as part of the research team. Support for the project was sought from, and provided by, the seed AMS staff and board, other Aboriginal Community Controlled Health Organisations, and general practices within the region of study, the National Cultural Educator and Cultural Mentor Network, and the Leaders in Indigenous Medical Education Network (a national group drawn from the university sector).

The James Cook University Human Research Ethics Committee approved this study (H8296) following review by Aboriginal and Torres Strait Ethics Advisors in accordance with the National Health and Medical Research Council guidelines.

Participants and recruitment

There will be four different groups of participants. Each will be described separately. Participants can withdraw from the study at any time with no consequences. Participants will be remunerated for their time with a gift voucher to the value of $50.

Aboriginal and Torres Strait Islander patient participants

Primary care, or GP care, for Aboriginal and Torres Strait Islander patients can be sought through a variety of services including private general practices, and services initiated and operated by Aboriginal and Torres Strait Islander communities for Aboriginal and Torres Strait Islander peoples (Aboriginal Community Controlled Health Organisations or ACCHOs). In this study, self-identifying, adult Aboriginal and Torres Strait Islander patients attending participating private general practices and ACCHOs in Queensland will be invited to participate.

ACCHOs and private general practices, agreeing to participate in the study, are those that have a pre-existing relationship with staff and/or board members at the seed AMS. Senior staff at these practices have been approached to inform them of the study and seek support for the study. Where appropriate, they have been invited to participate in governance structure of the project, through the expert panel. The practices are all within rural and regional Queensland. The three ACCHOs are geographically dispersed being at least 550 kms distant from each other. The private practices are near the seed AMS.

Patients will be invited by practice staff (not in a position of power), either verbally or through providing an information sheet at the end of their consultation, to participate in the study. This may be in the form of a telephone conversation or email if consultation is occurring via telehealth. All patients satisfying inclusion criteria at the ACCHOs will be approached, dependant on practice workflow and demands, until the sample size is achieved. Patients meeting inclusion criteria at the mainstream general practice will be purposively approached until sample size achieved; or a telephone call or letter sent using practice contact details inviting them to participate in the project. Inclusion criteria are: (a) the patient self-identifies as an Aboriginal and Torres Strait Islander person; (b) aged > 18 years; and (c) capacity to give informed consent.

Patients will be asked during the interview if they wish to be invited to participate in Phase 2 of the research project.

Registrar participants

One Queensland GP registrar training organisation, James Cook University General Practice Training (JCUGP), agreed to participate in the study after direct approach by the principal investigator, who has existing professional relationships with JCUGP senior staff. Registrars within JCUGP work across Queensland, including the Torres Strait Islands, but excluding the south-east corner of the state [48]. Within JCUGP region approximately 70,000 or two-thirds of Queensland's Aboriginal and Torres Strait Islander people live in diverse communities – from regional cities to remote islands [48]. Given the diversity of communities, the high population of Aboriginal and Torres Strait Islander peoples, and the number of registrars, sampling only one organisation was considered appropriate. All JCUGP registrars undertake mandatory cultural awareness training modules that are delivered by cultural educators. JCUGP also delivers cultural safety training which is informed by the Aboriginal and Torres Strait Islander Community. Many registrars will gain additional skills and experience throughout their hospital and general practice training.

In this study, all GP registrars undertaking active training with JCUGP will be invited to participate in the study. Registrars could be undertaking training in a range of settings including specialty-based hospital disciplines, rural generalist hospitals, AMSs, and mainstream general practices.

All JCU-GP registrars will be sent an invitation email which will include links to the participant information sheet, consent form and survey. Participants are asked to provide informed consent to completion of both survey and interview. They will be asked to include name and contact details (email or telephone) to allow the research assistant to contact them to schedule the interview. This identifying information will be stored securely and separately to the research data and a unique identifier code used to link the survey and interview data.

General practitioner participants

GPs, who have been working at the participating practices (see section *Aboriginal and Torres Strait Islander patient participants*) for more than six weeks, will be invited to participate in the project to explore practices that they perceive are culturally safe. All GPs will be invited by practice staff (not in a position of power), either verbally or through giving of an information sheet (hard-copy or emailed), to participate in the study.

Delphi participants

Participants will include Australian Aboriginal and Torres Strait Islander people who are patients, both Indigenous and non-Indigenous patient advocates, experts in Australian Aboriginal and Torres Strait Islander healthcare and health education (including GPs, medical educators, academics, and health workers), and other key stakeholders. Recruitment will occur by a variety of means including word-of-mouth, snowballing and invitation emails through existing networks of the research team and seed AMS.

Data collection

Data will be collected sequentially in three phases.

Phase 1

Phase 1 uses a concurrent embedded mixed methods approach and will gather both survey data and semi-structured interview data to explore the research questions [46]. Data will be collected in three parts, and across three groups of participants (Table 1). In this method, data will be collected and analysed concurrently and results from qualitative data synthesised with quantitative data. To avoid power imbalances and facilitation of frank answers, researchers with no pre-existing relationship to any of the participants, will complete data collection in Phase 1.

The data collection methodology will be described separately for Aboriginal and Torres Strait Islander patients, GP registrars and GPs. Informed consent will be obtained and recorded in electronic format, on Qualtrics, prior to completing the online survey. The consent will encompass both the survey and the subsequent interview. The research assistant will be available to aid where required.

Aboriginal and Torres Strait Islander patients

Part 1

Part 1 will involve administration of a Qualtrics® based survey considering demographic details of the participating patient, including age and gender. Further questions explore five selected social determinants of health that have been shown to contribute significantly to the health gap between Indigenous and non-Indigenous adults [52]. These determinants are household income, employment and hours worked, highest non-school qualification, level of schooling completed, and housing adequacy [52]. These social determinants are explored recognizing that the interaction between cultural safety, social factors and wellbeing is very complex and a method for assessing cultural safety needs to be cognizant of this relationship. The questions are mirrored from the Australian Bureau of Statistics census data [53].

Part 2

Part 2 will involve semi-structured interviews with patients to explore their understanding of cultural safety. The semi-structured interview guide was developed *de-novo* being informed by the literature, experience, and advice from a community advisory panel of Aboriginal and Torres Strait Islander people who are overseeing the project (Additional file 1: Appendix 1). One question asks patients to choose their preferred GP from 45

Table 1 Phase 1 – Data collection methodology

	Aboriginal and Torres Strait Islander patients	GP registrars and GPs
Part 1:	Survey Demographic details	Survey Demographic details Experience Cultural capability measurement tool [49] Measurement of attitude change scale [50] Self-reflection and insight scale [51]
Part 2	Semi-structured interviews exploring patient understanding and experience of cultural safety	Semi-structured interviews exploring registrar understanding of cultural safety
Part 3:	Detailed exploration of patient's perception of key areas identified in the cultural safety literature	Detailed exploration of registrar's perception of key areas identified in the cultural safety literature
Number of participants	We are aiming to recruit approximately ten patients from each of the four participating practices, but data collection will continue until the data produces no new insights and data is repeating	We are aiming to recruit approximately twenty GP registrars and three GPs from each of the four participating practices, but data collection will continue until the data produces no new insights and data is repeating

photographic different face images. This is designed to explore potential patient bias in a consultation. These images represent a diversity of gender, age, ethnicity, and appearance. Images include Aboriginal and Torres Strait Islander doctors, obtained from Indigenous health websites, and others from a free face generator (thispersondoesnotexist.xyz) [54].

The interview guide was reviewed by the whole research team, two independent GPs, and members of the community advisory panel. The survey and interview guide were piloted with two Aboriginal health workers. Interviews are expected to take 30–45 min. Participants will be offered face-to face or remote interviews, either video or audio only. Interviews will be recorded following confirmation of informed consent and then electronically transcribed. These transcripts will be checked for accuracy by a research assistant.

Part 3

At the end of semi-structured interviews, the interviewer will request patients rate the importance, from not important (one) to very important (five), of several factors when consulting their GP. These factors where identified from Australian medical education literature and included sociocultural differences [55], the importance of general consultation and communication skills, the ability to listen, respect, trust, and self-reflection [6]. Patients will be encouraged to justify or explain their response regarding the importance of knowing Australian history pre-colonisation, the experiences of Aboriginal and Torres Strait Islander people after colonisation and having medical knowledge and skills. In addition, they are asked to rate the importance of eye contact, the value of silence, the use of some traditional language, inclusion of spirituality in a consultation and the importance of including family, elders of other significant others in the consultation. Finally, participating patients will be asked to consider how important their own culture is to them and their identity and the importance of their own connection to land.

GP registrars and GPs

Part 1

Like patients, part 1 will involve administration of a Qualtrics®-based survey considering demographic details of the GP registrars including age, gender, postgraduate level, stage of training, training college, university of graduation, time lived in Australia, exposure to Aboriginal and Torres Strait Islander patients and type of current practice (AMS, hospital, or mainstream general practice). This information will be used to describe the participants, to determine if participants are representative of the JCUGP registrar cohort, and to provide context for qualitative data analysis.

The survey will include questions exploring the "being" and "is" of cultural safety regarding attitude and beliefs for comparison with the qualitative data. Numerous self-assessment tools exist to measure a learner's behaviour and attitude [56]. Validated survey questions from West et al.'s cultural capability measurement tool (developed for nurses) [56] and Ryder et al.'s measurement of attitude change [50] has been utilised. Ryder et al. developed and validated a questionnaire to measure attitude change in health professionals (including medical students) following completion of a cultural safety training program [48]. Both questionnaires by West et al. [56] and Ryder et al. [50] occur outside of the context of patient interaction and are self-assessed measures of attitude. The questions asked in both surveys share similarities and therefore, the questions were compared and rationalised by choosing one representative question from overlapping queries (Additional file 1: Appendix 2). As Ryder et al.'s research included medical students these questions were preferentially used. Wording of the survey is modified such that 'health professional' or 'student' is replaced with 'GP, 'Aboriginal people' is broadened to 'Aboriginal and Torres Strait Islander people', 'patient' is used instead of 'client', "GP consultation" substituted for "hospitalised patient's room" and "Prohibited" replaced with "limited or restricted" to avoid an 'all or nothing' type of question.

We altered the West et al. survey question: "Aboriginal and Torres Strait Islander peoples receive special treatment from government" to "Aboriginal and Torres Strait Islander peoples receive *unnecessary* special treatment from government". Investigators felt the original question could be interpreted by participants in this study as a knowledge assessment—about Australian government initiatives to close the gap on Indigenous health disparities [57] rather than a reflection of participants' attitude.

To consider registrar self-reflection, we examined 21 different questionnaires identified in a systematic search by Soemantri et al. [51]. Five questions from the Self-Reflection and Insight Scale (SRIS), looking at intention for reflection, were chosen by the research team as most appropriate and incorporated [58] into the final survey (Additional file 1: Appendix 2).

Part 2

Like patients, Part 2 will involve semi-structured interviews with GP registrars and GPs to explore their understanding of cultural safety. The semi-structured interview guide was developed in the same manner as the patient guide and is presented in Additional file 1: Appendix 3.

The survey and interview guide were piloted with two GP registrars and a recent GP fellow. Interviews are expected to take 30–45 min.

The interview will be conducted at least 5 days after the survey to minimise survey questions influencing responses in the semi-structured interviews. Participants will be offered face-to face or remote interviews, either video or audio only. Interviews will be recorded following confirmation of informed consent and then electronically transcribed. These transcripts will be checked for accuracy by a research assistant.

Part 3

Part 3, at the end of semi-structured interviews, the interviewer will request GP registrars and GPs to rate the same questions presented to the patient participants.

Phase 2

Findings from Phase 1 will be validated using a two-step qualitative approach to confirm essential elements of any potential cultural safety assessments in GP consultations.

Phase 2 will utilise an adapted nominal group technique (NGT). McMillan et al. [59] detailed a simplified model of NGT (silent generation, round robin, clarification, ranking and discussion). This project will incorporate the Indigenous research approach of yarning [60] in place of discussion. Bessarab and Ng'andu [60] describe research topic yarning as an "*informal and relaxed discussion through which both the researcher and participant journey together visiting places and topics of interest relevant to the research study*". It will also adopt similar methods as described by Woolley [61] to encourage discussion and debate on inclusion of elements from Stage 1 in a potential assessment tool:

> "*The Yarning Circle discussion involved the facilitator asking the other participants to describe any specific skills, knowledge or attitudes they felt were important…Participant comments under each… heading were captured as a phrase or statement on butcher's paper in front of the group so that participants were able to see the ideas generated. Visual representation of the data generated in the focus group enabled participants to come to an agreement about how each comment was summarised*".

As a primary aim for the project will be to develop a patient-driven assessment tool, only Australian Aboriginal peoples will be invited to consider element inclusion/exclusion in the first instance. Australian Aboriginal patients participating in Stage 1 will be invited to participate in the adapted NGT group. Other participants will be purposively sampled, though the networks of both the research team and participating practices and invited to participate. These will include additional Australian Aboriginal patients and Australian Aboriginal representatives from key stakeholder groups, including community. Once participants are known, advice will be sought from the expert panel regarding appropriateness of separate groups for patients and stakeholders to minimise any potential power differential. Snowball recruiting will be encouraged.

Ideally the adapted NGT will be conducted face-to-face but could be managed through an online meetings platform if circumstances require this approach. Following a written and verbal informed consent process, adapted NGT groups will be audio-recorded and transcribed as per individual semi-structured interviews and any written material collated or photographed.

Sample size

A maximum group size of seven has been recommended for NGT [59]. One to five adapted NGT groups will be conducted in geographically diverse locations. The number of adapted NGT will be dependent on number and scheduling requirements of participants.

Phase 3

Phase 3 involves a Delphi survey to further validate the findings of Phase 1 and 2. A Delphi technique (DT) uses a multi-stage process of anonymous questionnaires to create a highly structured group interaction [59]. Elements identified for inclusion in an assessment approach from Phase 2 adapted NGT will be collated and refined into a Delphi questionnaire. Links to consent and DT questionnaires will be emailed to participants and reminders sent to all participants. Qualtrics® will be used to administer the questionnaire online and collate responses electronically. Elements will be rated by participants on a Likert scale and free-text comments written to justify their response. The process will be repeated until consensus is reached about the elements which are important to include in an assessment of cultural safety.

Sample size

A panel size of 15 is suggested as optimal size for this technique [59].

Data analysis

Survey data will be descriptively analysed using Excel® to both characterise the participants and provide contextual data for assisting in interpreting the interview data. One researcher (KB) will analyse all interview and adapted NGT transcripts through a content analysis approach using theory-driven codes derived from the AHPRA definition of cultural safety (free from racism, knowledge, skills, attitude, behaviours, power differential) and emerging data-driven codes. NVivo® analysis software will be used when coding data, recording frequency of occurrence of item of interest, and collating key concepts. Interview data and coding will be checked and reviewed by other researchers and the research team will meet frequently to reflect and debrief to support the dependability and credibility of the data analysis.

This project will maintain transparency through the research process by input from the community panel, regular discussion with the seed AMS staff, peer examination of the data through conference presentations, ongoing journaling of personal reflexivity on the data, and identifying disconfirming evidence that is contrary to evidence supporting a theme. Multiple reviews of coding will be conducted to ensure agreement in the coding and to minimise bias of any individual researcher. In addition, KB will work with the community advisory panel during phases of thematic analysis and coding, further minimising the potential bias associated with the individual researcher.

Consensus elements from the three phases will be synthesised into a potential assessment model. Further research beyond this project will be required to pilot and validate the proposed assessment approach.

Reflexivity

The principal investigator, KB, is an experienced GP academic working in the seed AMS in south-east Queensland. Her cultural heritage is uncertain and is impacted by the complexities surrounding Aboriginal identity within Australia [62]. RW is an Aboriginal academic from Kunja Nations, NH an Aboriginal and Torres Strait Islander cultural educator for JCUGP, RE a senior researcher, TS and HW academic GPs, and LM an academic GP. A community advisory group of Aboriginal and Torres Strait Islander people, associated with the seed AMS, have been involved in the research since inception.

Discussion

This study will be one of the first to explore how cultural safety, as determined by Aboriginal and Torres Strait Islander peoples, can be assessed in general practice consultations. The study will explore how GPs and GP registrars perceive cultural safety with Aboriginal and Torres Strait Islander patients and alignment with the community derived AHPRA definition of cultural safety. As such we will compare the GP and GP registrar data and patient data to identify the concordance with each other and the AHPRA definition to help shape teaching and assessment of cultural safety.

This protocol is shared to stimulate awareness and discussion around this significant issue and prompt other studies in this area. We hypothesise that conceptualising the assessment of cultural safety through the multiple dimensions of a community-derived definition [19], the continuum of cultural safety [3, 4], educationally (using Miller's pyramid [33] and transformative learning theory [35]), Aboriginal ways of knowing, doing, and being [34], and social and emotional wellbeing [26] will allow an assessment outcome to reflect the complexity of cultural safety within general practice.

Key limitations to this study include that we are studying a relatively small number of participants in a geographically discrete region. While there are strengths in this geographically discrete approach, especially regarding specificity to the local cultural context, outcomes of this project should be assessed for wider application. In addition, we are relying on participants to self-describe their behaviours, and attitudes. With the GP and GP registrar surveys, responses in these questionnaires may not accurately reflect behaviour, or the opinion and experience of the patient [63]. Direct observation of practice may provide further insight into attributes of cultural safety.

This project has implications for practice and training of medical professionals both within Australia and internationally. Within Australia, culturally safe practice has been recognised by both the RACGP and ACRRM as a priority for inclusion in training programs. This protocol allows the exploration of cultural safety, as understood by patients, GPs, and registrars, and to identify gaps between the knowing, doing and being of general practice. This understanding is vital to allow the shaping and improvement of cultural safety training within GP training curricula and consideration of assessment of GP registrars knowing, showing, and doing.

However, this protocol also has potential within a wider context. Other areas of healthcare, including other medical specialities, allied health, dental and nursing, could benefit from similar studies exploring cultural safety amongst trainees. In the same way, an exploration of the process of developing safe care for culturally diverse peoples has potential benefits internationally. It is hoped that the sharing of this protocol offers opportunities to expand the knowledge base around culturally safe care more widely.

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12909-023-04249-6.

Additional file 1: Appendix 1. Semi-structured interview guide for patients. **Appendix 2.** Survey questions for GPs and GP registrars. **Appendix 3.** Semi-structured interview guide for GPs and GP registrars.

Acknowledgements

This study is supported by patients, staff and the community advisory panel at Goolburri Aboriginal Health Advancement, Toowoomba, Australia. It is a PhD dissertation protocol of the first author at The College of Medicine and Dentistry, James Cook University, Australia.

Authors' contributions

KB—wrote the main manuscript text and prepared figures. All authors reviewed and approved the manuscript.

Authors' information

Kay Brumpton is first author.

Funding

This study is funded through an Australian government Medical Research Futures Fund Clinician Researchers grant, and an Australian College of Rural and Remote Medicine educational research grant.

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available due to reasons of sensitivity but are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

The James Cook University Human Research Ethics Committee approved this study (H8296) following review by Aboriginal and Torres Strait Ethics Advisors in accordance with the National Health and Medical Research Council guidelines. Informed consent will be obtained and recorded in electronic format, on Qualtrics, prior to participating in the study. The consent will encompass both the survey and the subsequent interview. The research assistant will be available to aid where required.

Consent for publication

Not applicable for this protocol paper. Ethics approval received for publication of de-identified material with patient informed consent for the study.

Competing interests

The authors declare no competing interests.

Author details

[1]Rural Medical Education Australia, Toowoomba, Australia. [2]University of Southern Queensland, Toowoomba, Australia. [3]College of Medicine and Dentistry, James Cook University, Townsville, Australia.

Received: 23 February 2023 Accepted: 11 April 2023

References

1. Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Serv Res. 2014;14:99.
2. MacKean T, Fisher M, Friel S, Baum F. A framework to assess cultural safety in Australian public policy. Health Promot Int. 2019;35(2):340–51.
3. Ramsden I. Cultural safety and nursing education in Aotearoa and Te Waipounamu. Wellington: Victoria University; 2002.
4. Mashford- Pringle A, Skura C, Stutz S, Yohathasan T. What we heard: Indigenous Peoples and COVID-19. Waakebiness-Bryce Institute for Indigenous Health. Dalla Lana School of Public Health: University of Toronta; 2021.
5. Paul D, Hill S, Ewen S. Revealing the (in)competency of "cultural competency" in medical education. AlterNative. 2012;8(3):318–28.
6. Brumpton K, Evans R, Ward R, Sen Gupta T. A consistent definition of cultural safety within Australian health professional education: a scoping review. AlterNative. 2022:18(3):436–44.
7. Grant J, Parry Y, Guerin P. An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. Aust N Z J Public Health. 2013;37(3):250–6.
8. McKivett A, Paul D, Hudson N. Healing conversations: developing a practical framework for clinical communication between Aboriginal communities and healthcare practitioners. J Immigr Minor Health. 2019;21(3):596–605.
9. Liaw ST, Hasan I, Wade V, Canalese R, Kelaher M, Lau P, et al. Improving cultural respect to improve Aboriginal health in general practice: A multi-methods and multi-perspective pragmatic study. Aust Fam Physician. 2015;44(6):387–92.
10. Freeman T, Edwards T, Baum F, Lawless A, Jolley G, Javanparast S, et al. Cultural respect strategies in Australian Aboriginal primary health care services: Beyond education and training of practitioners. Aust N Z J Public Health. 2014;38(4):355–61.
11. Barnett L, Kendall E. Culturally appropriate methods for enhancing the participation of Aboriginal Australians in health-promoting programs. Health Promot J Austr. 2011;22(1):27–32.
12. Smith K, Fatima Y, Knight S. Are primary healthcare services culturally appropriate for Aboriginal people? Findings from a remote community. Aust J Prim Health. 2017;23(3):236–42.
13. Bennett B, Redfern H, Zubrzycki J. Cultural responsiveness in action: Co-constructing social work curriculum resources with Aboriginal communities. Br J Soc Work. 2018;48(3):808–25.
14. Chang ES, Simon M, Dong X. Integrating cultural humility into health care professional education and training. Adv Health Sci Educ. 2012;17(2):269–78.
15. Chapman R, Martin C, Smith T. Evaluation of staff cultural awareness before and after attending cultural awareness training in an Australian emergency department. Int Emerg Nurs. 2014;22(4):179–84.
16. Chong A, Renhard R, Wilson G, Willis J, Clarke A. Improving cultural sensitivity to Indigenous people in Australian hospitals a continuous quality improvement approach. Focus on Health Professional Education : A Multi-disciplinary Journal. 2011;13(1):84–97.
17. Isaacs AN, Raymond A, Jacob E, Jones J, McGrail M, Drysdale M. Cultural desire need not improve with cultural knowledge: A cross-sectional study of student nurses. Nurse Educ Pract. 2016;19:91–6.
18. Omeri A, Ahern M. Utilising culturally congruent strategies to enhance recruitment and retention of Australian indigenous nursing students. J Transcult Nurs. 1999;10(2):150–5.
19. Ahpra & National Boards. A consistent baseline definition of cultural safety for the National Scheme. Canberra: National Registration and Accreditation Scheme; 2019.
20. Australian Bureau of Statistics (2021). Aboriginal and Torres Strait Islander people:census - reference period 2021. https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/aboriginal-and-torres-strait-islander-people-census/2021. ABS: Canberra; 2022. Accessed 30 Apr 2023.
21. Australian Government Department of Health and Aged Care. Status and determinants of Aboriginal and Torres Strait Islander health. https://www.health.gov.au/topics/aboriginal-and-torres-strait-islander-health/status-and-determinants. DOHA: Canberra; 2021. Accessed 30 Apr 2023.
22. Ahpra & National Boards. The National Scheme's Aboriginal and TorresStrait Islander health and cultural safety strategy 2020–2025. Canberra:Ahpra and National Boards; 2020.
23. Australian Institute of Health and Welfare. Cultural safety in health care for Indigenous Australians: monitoring framework. Canberra: AIHW; 2022.
24. Australian Medical Council Limited. Review of the accreditation standards for primary medical programs. https://www.amc.org.au/review-of-accreditation-standards-for-primary-medical-programs-medical-schools/. AMC; 2022. Accessed 30 Apr 2023.
25. Anderson IP, Robson BP, Connolly MMPH, Al-Yaman FP, Bjertness EP, King AMD, et al. Indigenous and tribal peoples' health (The Lancet-Lowitja Institute Global Collaboration): a population study. Lancet. 2016;388(10040):131–57.
26. Gee G, Dudgeon P, Schultz C, Hart A, Kelly K. Social and emotional wellbeing and mental health: an Aboriginal perspective. Chapter 4, In: Dudgeon P, MilroyM, Walker R,(editors). Working together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice – Revised Ed., in National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017–2023. Revised ed. https://www.niaa.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf. Canberra: Department of Prime Minister andCabinet; 2017. p. 55. Accessed 30 Apr 2023.
27. Royal Australian College of General Practitioners. Standards for general practices. 5th ed. East Melbourne: RACGP; 2020.
28. Brumpton K, Sen Gupta T, Evans R, Ward R. Assessment of cultural safety in a post-Objective Structured Clinical Examination (OSCE) era. AJGP. 2022;51(1–2):90–3.

29. Royal Australian College of General Practitioners. 2022 RACGP curriculum and syllabus for Australian general practice. Melbourne: RACGP; 2022.
30. Australian College of Rural and Remote Medicine. Rural generalist curriculum. Brisbane: ACRRM; 2020.
31. Australian Medical Council Limited. Proposed graduate outcome statements:draft for consultation. https://www.amc.org.au/wp-content/uploads/2022/09/ATTACHMENT-A-Proposed-Graduate-Outcome-Statements-Draft-for-consultation-August-2022.pdf. Canberra: AMC; 2022. Accessed 30 Apr 2023.
32. Watt K, Abbott P, Reath J. Developing cultural competence in general practitioners: an integrative review of the literature. BMC Fam Pract. 2016;17(1):1–11.
33. Cruess R, Cruess S, Steinert Y. Amending Miller's pyramid to include professional identity formation. Acad Med. 2016;91(2):180–5.
34. Martin K, Mirraboopa B. Ways of knowing, being and doing: a theoretical framework and methods for Indigenous and Indigenist re-search. J Aust Stud. 2003;27(76):203–14.
35. Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010;376(9756):1923–58.
36. General Practice Registrars Australia. Pathways into general practice. https://gpra.org.au/training/fellowship-pathways/GPRA; 2022. Accessed 30 Apr 2023.
37. Royal Australian College of General Practitioners. Examination guide. https://www.racgp.org.au/educa tion/registrars/fracgp-exams/exam-support-program-resources/examination-guide. Melbourne: RACGP; 2022. Accessed 30 Apr 2023.
38. Australian College of Rural and Remote Medicine A. Fellowship assessment handbook. https://www.acrrm.org.au/docs/default-source/all-files/handbook-fellowship-assessment.pdf?sfvrsn=42ba86eb_8. Brisbane: ACRRM; 2019. Accessed 30 Apr 2023.
39. Sen Gupta T, Campbell D, Chater A, Rosenthal D, Saul L, Connaughton K, et al. Fellowship of the Australian College of Rural & Remote Medicine (FACRRM) assessment: a review of the first 12 years. MedEdPublish. 2020;9(100).
40. Brouwers M, Custers J, Bazelmans E, Van Weel C, Laan R, van Weel-Baumgarten E. Assessment of medical students' integrated clinical communication skills: development of a tailor-made assessment tool. BMC Med Educ. 2019;19(118):1–10.
41. Al-Eraky M, Marei H. A fresh look at Miller's pyramid: assessment at the "Is" and 'Do" levels. Med Educ. 2016;50:1253–7.
42. Broadwell M. Teaching for learning (XVI). The Gospel Guardian. 1969;20(41):1–3a.
43. Jalla C, Hayden G. Aboriginal health research is not black and white - lessons from the field. Australian Indigenous HelathBulletin. 2014;14(3).
44. Patton M. Qualitative Research & Evaluation Methods. 4th ed. Los Angeles: SAFE; 2005.
45. Allemang B, Sitter K, Dimitropoulos G. Pragmatism as a paradigm for patient-oriented research. Health Expectat. 2022;25(1):38–47.
46. Creswell J, Plano CV. Designing and conducting mixed methods research. Thousand Oaks: Sage; 2007.
47. National Health and Medical Research Council. Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: guidelines for researchers and stakeholders. Canberra: Commonwealth of Australia; 2018.
48. James Cook University. General Practice training. Townsville: JCU; 2022. https://www.jcugp.edu.au/. JCU: Townsville; 2022. Accessed April 30, 2023.
49. West R, Wrigley S, Mills K, Taylor K, Rowland D, Creedy D. Development of a First Peoples-led cultural capability measurement tool: a pilot study with midwifery students. Women Birth. 2017;30(3):236–44.
50. Ryder C, MacKean T, Ullah S, Burton H, Halls H, McDermott D, et al. Development and validation of a questionnaire to measure attitude change in health professionals after completion of an Aboriginal health and cultural safety training programme. Aust J Indigenous Educ. 2019;48(1):24–38.
51. Soemantri D, Mccoll G, Dodds, A. Measuring medical students' reflection on their learning: modification and validation of the motivated strategies for learning questionnaire (MSLQ). BMC Med Educ. 2018;18(1):1–10.
52. Australian Institute of Health and Welfare. Determinants of health for Indigenous Australians. https://www.aihw.gov.au/reports/australias-health/social-determinants-and-indigenous-health health. Canberra: AIHW;2020.
53. Australian Bureau of Statistics. Census household form. Canberrra: Commonwealth of Australia; 2016.
54. Vincent J. ThisPersonDoesNotExist.com uses AI to generate endless fake faces: Vox Media; 2019. Available from: https://www.theverge.com/tldr/2019/2/15/18226005/ai-generated-fake-people-portraits-thispersondoesnotexist-stylegan. Accessed 30 Apr 2023.
55. Jongen C, McCalman J, Bainbridge R, Clifford A. Cultural Competence in Health - A review of the Evidence. Singapore: Springer Briefs in Public Health; 2018.
56. West R, Mills K, Rowland D, Creedy DK. Validation of the first peoples cultural capability measurement tool with undergraduate health students: a descriptive cohort study. Nurse Educ Today. 2018;64:166–71.
57. Productivity Commission. Closing the gap annual data compilation report July 2022. https://www.pc.gov.au/closing-the-gap-data/annual-data-report/report/closing-the-gap-annual-data-compilation-report-july2022.pdf. Canberra: Commonwealth of Australia, Office of the Prime Minister and Cabinet; 2022. Accessed 30 Apr 2023.
58. Naeimi L, Abbaszadeh M, Mirzazadeh A, Sima A, Nedjat S, SH. Validating self-reflection and insight scale to measure readiness for self-regulated learning. J Educ Health Promotion. 2019;8:1–7.
59. McMillan S, King M, Tully M. How to use the nominal group and Delphi techniques. Int J Clin Pharm. 2016;38:655–62.
60. Bessarab D, Ng'andu B. Yarning about yarning as a legitimate method in Indigenous research. Int J Crit Indig. 2010;3(1):37–50.
61. Woolley T, Sivamalai S, Ross S, Duffy G, Miller A. Indigenous perspectives on the desired attributes of medical graduates practising in remote communities: a Northwest Queensland pilot study. Aust J Rural Health. 2013;21(2):90–6.
62. Carlson B. The politics of identity: who counts as Aboriginal today? Canberra: Aboriginal Studies Press; 2016.
63. Carr S, Johnson, P. Does self reflection and insight correlate with academic performance in medical students? BMC Med Ed. 2013;13(113):113–7.

Publisher's Note

No.	Description of the standard	Page number
#1	Title: Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	2
#2	Abstract: Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusion	2
#3	Problem formulation: Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	4-5
#4	Purpose of research question: Purpose of the study and specific objectives or questions	5
#5	Qualitative approach and research paradigm: Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale*	6
#6	Researcher characteristics and reflexivity: Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	7
#7	Context: Setting/site and salient contextual factors; rationale**	6
#8	Sampling strategy: How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale	6
#9	Ethical issues pertaining to human subjects: Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security is	20
#10	Data collection methods: Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	6
#11	Data collection instruments and technology: Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	6
#12	Units of study: Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	7
#13	Data processing: - Methods for processing data prior to and during	7

	analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	
#14	Data analysis: - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	7
#15	Techniques to enhance trustworthiness: - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale*	6
#16	Synthesis and interpretation: Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	7
#17	Links to empirical data: Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic finding	7-18
#18	Integration with prior work, implications, transferability, and contribution(s) to the field: Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	18
#19	Limitations: Trustworthiness and limitations of findings	2-3
#20	Conflicts of interest: Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	20
#21	Funding: Sources of funding and other support; role of funders in data collection, interpretation, and reporting	21

BMJ Open

Exploring what GP registrars consider distinctive to consultations with Aboriginal and Torres Strait Islander patients: a mixed method study.

Journal:	*BMJ Open*
Manuscript ID	bmjopen-2023-082137.R2
Article Type:	Original research
Date Submitted by the Author:	09-May-2024
Complete List of Authors:	Brumpton, Kay; Griffith University Griffith Health, School of Medicine and Dentistry; Rural Medical Education Australia Woodall, Hannah; Rural Medical Education Australia; James Cook University College of Medicine and Dentistry Evans, Rebecca; James Cook University, College of Medicine and Dentistry and Anton Breinl Research Centre for Health Systems Strengthening Neill, Henry; James Cook University Sen Gupta, Tarun; James Cook University College of Medicine and Dentistry McArthur, Lawrie; The University of Adelaide Ward, Raelene; University of Southern Queensland
Primary Subject Heading:	General practice / Family practice
Secondary Subject Heading:	Medical education and training, Patient-centred medicine
Keywords:	Health Equity, MEDICAL EDUCATION & TRAINING, Primary Health Care

I, the Submitting Author has the right to grant and does grant on behalf of all authors of the Work (as defined in the below author licence), an exclusive licence and/or a non-exclusive licence for contributions from authors who are: i) UK Crown employees; ii) where BMJ has agreed a CC-BY licence shall apply, and/or iii) in accordance with the terms applicable for US Federal Government officers or employees acting as part of their official duties; on a worldwide, perpetual, irrevocable, royalty-free basis to BMJ Publishing Group Ltd ("BMJ") its licensees and where the relevant Journal is co-owned by BMJ to the co-owners of the Journal, to publish the Work in this journal and any other BMJ products and to exploit all rights, as set out in our licence.

The Submitting Author accepts and understands that any supply made under these terms is made by BMJ to the Submitting Author unless you are acting as an employee on behalf of your employer or a postgraduate student of an affiliated institution which is paying any applicable article publishing charge ("APC") for Open Access articles. Where the Submitting Author wishes to make the Work available on an Open Access basis (and intends to pay the relevant APC), the terms of reuse of such Open Access shall be governed by a Creative Commons licence – details of these licences and which Creative Commons licence will apply to this Work are set out in our licence referred to above.

Other than as permitted in any relevant BMJ Author's Self Archiving Policies, I confirm this Work has not been accepted for publication elsewhere, is not being considered for publication elsewhere and does not duplicate material already published. I confirm all authors consent to publication of this Work and authorise the granting of this licence.

For peer review only

Protected by copyright, including for uses related to text and data mining, AI training, and similar technologies.
Enseignement Superieur (ABES) .

Exploring what GP registrars consider distinctive to consultations with Aboriginal and Torres Strait Islander patients: a mixed method study.

Kay Brumpton[1,2,3*], Hannah Woodall[1, 2,3], Rebecca Evans[3], Henry Neill[3], Tarun Sen Gupta[3], Lawrie McArthur[4], Raelene Ward[5]

[1] Griffith University, Gold Coast Campus, Southport, Australia

[2] Rural Medical Education Australia, Toowoomba, Australia

[3] James Cook University, Townsville, Australia

[4] The University of Adelaide, Adelaide, Australia

[5] University of Southern Queensland, Toowoomba, Australia

*Corresponding Author.

Kay Brumpton

190 Hume Street, East Toowoomba, QLD, 4350.

k.brumpton@griffith.edu.au

ABSTRACT

Background and objective Understanding what general practice (GP) registrars consider as distinctive in their consultations with Aboriginal and Torres Strait Islander patients may help bridge the gap between patient-determined cultural safety and current medical and behavioural practice. This project seeks to explore what GP registrars perceive as distinctive to their consultations with Aboriginal and Torres Strait Islander patients. Methods This mixed methods study involved a survey considering demographic details of GP registrars, questionnaire regarding attitude and cultural capability, and semi-structured interviews.

Results Twenty-six registrars completed the survey. Sixteen registrars completed both the survey and the interview. Despite recognising a need to close the gap on health outcomes for Aboriginal and Torres Strait Islander peoples and wanting to do things differently, most registrars adopted a generic approach to all consultations.

Discussion This study suggests that overall, GP registrars want do improve the health of Aboriginal and Torres Strait Islander patients, but do not want their consultations with Aboriginal and Torres Strait Islander patients to be distinctive. Registrars appeared to approach all consultations in a similar manner using predominantly patient-centred care principles. Given the importance of a culturally safe consultation, it is important for us to consider how to increasingly transform these learners and teach cultural safety in this context.

Strengths and limitations of this study:

- Our study was co-created with Aboriginal and Torres Strait Islander people and aimed to ensure the research was respectful of Aboriginal cultural values and beliefs and responsive to community priorities.
- Our mixed-methods study allowed comparison of survey and interview data to better understand registrars and how they considered Indigenous health.
- This study relied on registrar self-assessment and self-reporting and did not attempt to measure registrar insight or observed practicing behaviour and outcomes.

Introduction

Australian general practice aims to provide “person-centred, continuing, comprehensive and coordinated whole-person healthcare to individuals and families.”(1). Foundational to this approach is the patient-general practitioner (GP) partnership and acknowledgement of patient ideas, expectations, and values (2). Patient-centred care can help improve patient outcomes and is recognised as a key component of high-quality general practice care (3). Similarly, culturally safe care is considered an Australian national health priority for improving the health of Australia’s Indigenous population, who continue to experience the negative impacts of colonisation (4). The Australian National Scheme’s Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 vision is that patient safety is the norm for Australian Aboriginal and Torres Strait Islander peoples (4). The Australian National Scheme’s vision links clinical and cultural safety and recognises that cultural safety should be defined by Aboriginal and Torres Strait Islander peoples (4).

Numerous models for a patient-centred GP consultation are available to assist the GP to navigate a consultation effectively and efficiently (5). Within the Australian general practice context, medical students and GP registrars are frequently taught to structure their consultation on the Calvary-Cambridge model (starting the consultation, gathering information, physical examination, explanation and education, and closure of the consultation) (6). To the Calvary-Cambridge model is added Neighbour’s advice for preparing for the consultation and safety-netting (7), Pendleton’s ‘ICE’ acronym (the patient’s ideas, concerns, and expectations) (8), and Murtagh’s safe diagnostic strategy and consideration of masquerades (9). However, current models are not specifically designed to address the health and cultural needs of diverse, disadvantaged or marginalised populations, such as Aboriginal and Torres Strait Islander peoples (3) nor are they validated as culturally safe models of care.

New Zealand, a country with similar colonial history to Australia, has adopted a framework for consultations that aims to provide a culturally safer consultation for Māori patients and their families (10). This Meihana Model of consultation considers connection between the patient and their support networks through physical, spiritual, and environmental wellbeing, consciousness, and awareness. Furthermore, it examines the impact of marginalisation, colonisation, racism and migration on the patient and consultation (10). The Meihana model is integrated with the Hui process (10) - a process that is not dissimilar to the Calvary-Cambridge model (6) and involves initial greeting and engagement, making a connection and building relationships, attending to the agenda, and closing the consultation.

Within the Australian context, McKivett has proposed a clinical communication framework based on health equity and understanding the impact of patient-community, racism, colonisation, and marginalisation (11). However, this is a theoretical model and is currently lacking a guide for translation into clinical practice. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing uses Gee et. al.'s model of social and emotional wellbeing to provide a structure for registrars to consider the historical, political and social determinants of health and the seven overlapping domains of body, mind and emotions, family and kin, community, culture, country, and spirituality and ancestors (12).

However, within a GP consultation, even when consultation models are used, identifying culturally safe and unsafe care can be challenging, either through being invisible to or ignored by healthcare providers. Additionally, a lack of universal understanding of cultural safety has increased the challenge of identifying culturally safe care (13-15). To progress both patient care and the research agenda about cultural safety, the Australian Health Practitioner Agency (AHPRA) released a community-derived consensus statement defining cultural safety in 2019. We use this definition in our study.

> *"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise (sic) is ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising (sic) behaviors and power differentials in delivering safe, accessible and responsive healthcare free of racism*" (16).

In this study we aim to explore what GP registrars consider distinctive to their consultations with Aboriginal and Torres Strait Islander peoples. This article is part of a larger study aimed at developing a tool for assessing cultural safety in GP consultation.

Methods

Research design

A detailed description of the methodology has been published (17). This phase of the study involves a mixed method approach to understand what GP registrars consider as distinctive to consultations with Aboriginal and Torres Strait Islander patients.

Participants

All GP registrars undertaking active training in 2022 with a rural and regional Australian (Queensland-based) GP registrar training organisation (GPRTO) were invited to participate in the study.

Patient and public involvement

A community advisory group of Aboriginal and Torres Strait Islander people have been involved in the research since inception to ensure the research is respectful of Aboriginal cultural values and beliefs and responsive to community priorities. The advisory group have advocated for the research, facilitated community liaison, provided advice on study design, and contributed to interpreting the data through discussing the key themes and example quotes. The research question was co-created between the research team and the advisory group. Patients were not involved in this phase of the study.

Data collection

Data collection was in two parts. Part 1 involved a survey considering demographic details of the GP registrars and select questions from an Australian cultural capability self-assessment tool measuring respect, communication, safety and quality, reflection and advocacy (18) and an Australian self-assessment tool measuring attitude change (19). When queries in these surveys overlapped, the attitude change measurement questions were preferentially used due to its previous use with medical students, as opposed to mostly nursing students. The survey was followed by semi-structured interviews with GP registrars to explore their perception of consultations with Aboriginal and Torres Strait Islander patients. At the end of the semi-structured interview, the interviewer requested participants use a 5-scale Likert score to rate the importance of elements traditionally associated with culturally safe care (eye contact, silence, the use of traditional language, inclusion of spirituality in a consultation, and the importance of including family/elders in the consultation (17). (See online supplemental survey and interview guide). Participants provided written informed consent.

Data analysis:

Survey data was descriptively analysed to both characterise the cases and provide contextual data for assisting in interpreting the interview data. Transcripts were studied using a content analysis (20) approach using theory-driven codes derived from the AHPRA definition of cultural safety (and emerging data-driven codes) (16). Codes included ongoing critical reflection, knowledge (language, connection to country, importance of family, spirituality, colonisation), skills, attitudes, practicing behaviors (communication strategy, consultation model), and free of racism (culturally unsafe care, understanding of healthcare initiatives to improve patient outcomes, patient choice of GP).

The survey results are reported alongside the interview data to add strength and meaning to registrar comments or to compare with interview results.

Reflexivity:

The principal investigator Author (A) 1 is an experienced GP academic working in an Aboriginal Medical Service. A2 is a GP clinician researcher, A3 a clinician researcher, A4 an Aboriginal cultural educator for the GPRTO, A5 and A6 are clinical academics, and the latter is director of the GPRTO. A7 is an Aboriginal academic from Kunja Nations. The research assistant is an evaluation coordinator with the GPRTO and conducted registrar interviews.

Results

Participant characteristics

A total of 26 registrars responded to the recruitment email and completed the survey. Of these, 16 registrars also completed an interview. All 26 survey respondents agreed to be interviewed, but practicalities of interview organisation resulted in only 16 registrars, including two registrars who self-identified as Aboriginal and Torres Strait Islander, being interviewed. Most registrars were less than 34 years old, had graduated from an Australian university and had limited experience in Aboriginal and Torres Strait Islander health.

A total of 618 minutes of audio-recording was analysed. The median length of interviews was 33.4 minutes with the longest interview 95 minutes and the shortest 18 minutes.

We report the data under three major content themes including (1) how registrars structure their consultation, (2) how registrars demonstrate cultural safety, and (3) registrars' attitude towards Aboriginal and Torres Strait Islander peoples.

Theme 1: Structure of the consultation

Two subthemes were identified which describe how most registrars do not identify any distinctive features in their consultations with Aboriginal and Torres Strait Islander patients.

1.1 Alignment with patient centred care

Registrars did not specifically identify any theoretical models that they used to structure a consultation (for example, the Calvary-Cambridge model). Registrars described characteristics of consultations that aligned with patient-centred care and that emphasised a holistic approach with continuity of care (table 1).

1.2 Similar approach for all patients whether Indigenous or non-Indigenous

Despite recognising a need to close the gap on health outcomes for Aboriginal and Torres Strait Islander peoples and wanting to do things differently, most registrars adopted a generic approach to all consultations. Nearly half of the registrars indicated that they would treat Aboriginal and Torres Strait Islander patients the same as other patients (Figure 1) and had a similar approach to consultations for all patients, apart from additional health promotion and screening (table 1). It was unclear from these statements if registrars were implying that patients have the right to equitable and non-racist healthcare or that the delivery of healthcare should be homogeneous. In addition, registrars provided limited examples of how a patient's Aboriginal and Torres Strait Islander identity or knowing about colonisation, influenced their clinical practice. Despite wanting to treat all patients the same, most registrars considered a Western medical model of health care did not meet the needs of Aboriginal and Torres Strait Islander patients (Figure 1).

One registrar had a very narrow application of cultural safety describing it as a discrete component of the consultation and that cultural safety was determined within the first stages of a consultation.

> And that the cultural safety stuff is actually almost like a barrier that you need to get over.

> And once you get that out of the way the interaction in the consult becomes like any other interaction and consult with any other patient... (6389)

Registrars did not appear to have a structured approach to considering elements of wellbeing such as connection to community, family and kinship, mind and emotions, or spirituality.

Table 1: Structure of a consultation with Aboriginal and Torres Strait Islander patients as described by GP registrars.

Subtheme	Participant quotes
Structure of the consultation	
Alignment with patient-centred care	I think what working in Aboriginal and Torres Strait Islander health has taught me as well is that to appreciate the person within the context of them, their family and their community and their culture. And I think the fact that I'm open to that makes it a little bit easier for Aboriginal and Torres Strait Islander people to come to me. (1131)
Similar approach for all patients whether Indigenous or non-Indigenous	I usually do very much the same thing as I do with other people. But I think in terms of certain things, as in screening or other things that are slightly different for Aboriginal population versus the non-Aboriginal population, I kind of just do a blanket statement and say, "This is because of your background that you identify yourself as [Aboriginal and Torres Strait Islander] there will be this and this, this, this, that needs to be done just for your health sake…I do offer them health assessments and stuff like that…So I think that's something different because you're

	eligible for those things. But I don't really treat them any different really. I see them as the same. (6434)

Theme 2: Demonstration of cultural safety

Two subthemes were identified which describe communication skills and the GP environment.

2.1 Communication skills (non-verbal and verbal)

Registrars described demonstrating culturally safe care through focussing on communication skills with Aboriginal and Torres Strait Islander patients and considered communication skills equally as important as clinical skills (Figure 1).

Silence in a consultation was rated as important (average 3.875/5 on the Likert scale), but not considered distinctive to consultations with Aboriginal and Torres Strait Islander patients. Registrars were divided on the importance of eye contact with patients and variably described approaches to determining the appropriateness of eye contact for individual patients (Table 2). Appropriate eye contact with patients was clearly a concern for registrars with several describing an “eye-dance” when trying to gauge from social cues if the patient was comfortable with eye-contact. Registrars also reflected on how eye contact, or lack of eye contact, made them feel: rather than how the patient felt.

Registrars described the importance of other non-verbal communication skills such as listening, body position/stance, and physical touch. One registrar mentioned physical touch as part of culturally safe care, reflecting “it was a good thing” without considering how the patient felt about this contact (Table 2). Registrars were sometimes aware of power differentials and attempted to address this by using wearing casual clothing, and adopting a body posture that did not create a physical height gradient (Table 2).

Registrars frequently spoke about use of informal language and simplifying speech for patients (including slang and humour), avoiding jargon, mirroring a patient's speech, and questioning patients' understanding Table 2). Many registrars described a conversational or yarning approach to a consultation, implying a two-way equal exchange, but frequently used language suggesting dominance or paternalism such as "talking to them", and "where I can express myself".

Registrars described enquiring about connection to country and/or family to build rapport with patients (Table 2). Registrars appeared to assume this was a safe question even when patients described loss of connection to family and country. Registrars also described asking "Are you of Aboriginal or Torres Strait Islander origin?" as both a barrier and facilitator to creating rapport with patients. Within Australian general practice it is recommended that this question is asked at every presentation (21). Some registrars were concerned about how not to be racist in asking patients to identify their ethnicity or when applying an epidemiological approach to the consultation. Other registrars assumed the question was safe or facilitated patient safety (Table 2). Registrars grappled differently with the concept that identification as an Aboriginal and Torres Strait Islander person may be fluid (Table 2) and at times patients may choose not to identify. Racism, and lack of recognition that fair-skinned people may identify as Aboriginal and Torres Strait Islander, was also demonstrated by a registrar who described a culturally unsafe approach to consultations by interrupting "white people" when they are taking a narrative or yarning approach within the consultation. Other registrars assumed that because the patient appeared to be Caucasian and/or of higher socio-economic status that they would not be affected by colonial failings.

Table 2: Communication skills used by registrars when consulting with Indigenous patients.

Subtheme	Participant quotes
Eye contact	…if I have a patient who I've seen from the chart is Indigenous, I normally start off avoiding eye contact initially and then just kind of see what they're doing to then see, is this person also doing it [avoiding eye contact]? And then try and feel out early on, does it seem like they're looking away or uncomfortable? Or if I look them in the eyes, do they appreciate that and prefer that?" (4091)
Other non-verbal communication skills	I actually found that touch was actually a good thing: sitting there and like actually holding their hand (6389). … I try and sit down if I can…So there isn't... [a feeling] I'm standing over them… And a lot of body language issues like not being necessarily front on, it can be kind of confrontational in the same way as the eye contact, sitting rather than standing over them. (4091)
Use of informal language (including slang and humour)	I guess the biggest thing I try to do is not create like a authority type situation where I am above them by any means. Just because I'm a doctor, I try to be as casual as I can. I want them to treat me like somebody …that they're just talking to casually and that they would want to just tell everything to…So, I guess appropriate understanding, common slang terms and then appropriate words to use in return... So, things like when they say that, oh, "This is deadly". (2601)
Enquiry about connection to country	One thing I learned after our training as well actually is that often when we've got some time, especially after doing our consult, it is just to ask a little bit about, you know, where are you from and like how long have you been there? Is that is that where your family is from or just try to get a bit more of an understanding? I have found that when I've asked those questions, I found out a lot of surprising things... (2601)

Use of the question, “Are you of Aboriginal or Torres Strait Islander origin?”	I know there's one time where it was a new patient to me, and I was just filling up the system for the patient's profile. And I think rather than saying, "Do you identify yourself as?", you know, in a more politically correct way, I kind of just said, oh, "Are you Aboriginal?” And then they're like, “Yeah, well, I can be, can't I?” And I was like, “Oh, no, I didn't mean like that, you know?” Yeah. So, I think it just slipped too quickly versus me processing it and using it the more PC [politically correct] way of asking. Yeah. So, I had to quickly say to them, “No, no, no, I didn't mean that. I just meant I just need to fill up your information. Doesn’t matter who you identify, what you identify as, it’s just with the Aboriginal status, you do get a lot more perks or a lot more things that we need to look into. (6434). But on the flip side, I'm blatantly asking, "Are you a particular race?", so that I could treat you accordingly. So, I'm very conflicted with that sometimes. Or a young child that comes in asking them like, have you had those extra vaccines because you're at risk of this and this. So, it's so, I, I try to say I'm trying to be professional, but I can see how some people can see that as offensive. It's like, "Oh, how dare you ask me that, so I'm lesser so I need more vaccines or need...?" (3270) I don't tend to ask [about identity] and that's because it's already collected. So, I already know from the information. If it's not written there, it often comes up though, if I'm having to do additional paperwork, then I say, “I just I would like to check. Do you identify as Aboriginal or Torres Strait Islander?” …And, so, I often don't necessarily ask them, particularly in the consult every time. (7400)

258

2.2 GP environment (safe and welcoming environment, appointment times, family, privacy, and spirituality)

Several registrars described creating a safe welcoming environment for Aboriginal and Torres Strait Islander patients through displaying Aboriginal flags, maps, artwork, acknowledgements to country and employment of Aboriginal and Torres Strait Islander staff within the practice. An Aboriginal and Torres Strait Islander registrar spoke of the physical environment being less important than registrar's attitude and communication skills in the delivery of culturally safe care (9304). Flexible and longer appointment times were seen as an important way of improving access to care (Table 3). About one third of registrars indicated that the presence of two or more family members in a consultation is disruptive and should be limited or restricted (Figure 1). However, in interviews registrars recognised the importance of family within consultations. All registrars agreed (n=6) or strongly agreed (n=19) that the quality of patient care could be compromised if a GP was oblivious to the family's cultural attributes and values. However, as mentioned previously, registrars were able to give limited examples of how this occurs in practice.

Other factors registrars considered important in demonstrating cultural safety included the provision of culturally tailored patient education, culturally appropriate referrals, patient consent, confidentiality, and privacy (Table 3). Registrars had divergent views on the importance of being considerate of spirituality in a consultation. An Aboriginal and Torres Strait Islander registrar spoke of considering spirituality as part of providing holistic care (Table 3).

<u>Table 3: Adapting the GP environment when consulting with Aboriginal and Torres Strait Islander patients.</u>

Subtheme	Participant quote

Safe welcoming environment	I don't work in a practice where there's Aboriginal posters everywhere. I work in a practice where it's not very welcoming at all and that's something that I will change. But the aesthetics are secondary to actually being open and honest in your communication and accepting people for who they are on their journey and helping them to progress their health journey in a way that it's just enough for them. (9304)
Inclusion of family	I always offer for a family member to be present because I think as much as support as I can give, often times family members [can] provide way more emotional support. (6278)
Privacy	But privacy is really number one…. And I actually found in a way, in a weird way, not having an Indigenous background sometimes made them prefer me as opposed to go there because there was the workers who were the aunties or the cousins or the all in the community and they were they didn't want word getting out about certain things. (6389)
Spirituality	Spirituality isn't something I would identify with Aboriginal culture so much (7216). I think it's very important because that's part of their I guess their identity and the medical perspective is also important to consider. Like, not like we always talk in med school spirituality doesn't mean psychosis and hallucinations (6278). It [spirituality] underpins attitudes to health, attitudes to healing and health for Aboriginal people is a holistic thing. It's not just I hurt my toe,

	or I've got a chest pain, it's got to do with everything else that's going on in their life. And that includes spirituality. (9304)

Theme 3: Attitude

Registrars described a variety of attitudes that they considered to be important in consultations with Aboriginal and Torres Strait Islander patients, particularly being non-judgemental, open-minded, kind, and respectful (Table 4).

Registrars thought they were demonstrating respect when acknowledging a person's Indigenous status, being considerate of local customs, providing patient-centred care, referral to culturally appropriate services, treating Aboriginal and Torres Strait Islander patients the same as other patients, and having an open-minded and non-judgemental attitude. Registrars minimised potential power differentials by expressing the similarities they have with Aboriginal and Torres Strait Islander patients. This included similar family structures, being darker skinned or also identifying as Aboriginal and Torres Strait Islander.

Registrars described their Aboriginal and Torres Strait Islander patients in a variety of ways and frequently referred to Aboriginal and Torres Strait Islander patients as being like themselves or not different to other patients. However, many of the descriptors "othered" Aboriginal and Torres Strait Islander people, were from a deficit perspective, and at times appeared to be unconsciously racist. Similarly, describing initiatives to achieve health equity as "perks" further marginalised the disadvantaged. A few registrars described treating Aboriginal and Torres Strait Islander patients using the moral rule of "treat others the way you want to be treated". Registrars regularly referred to Aboriginal and Torres Strait patients "as human" or "like a human" (Table 4). Negative descriptors of Aboriginal and Torres Strait Islander patients were commonly used including disadvantage, dysfunction, chronic disease sufferers, substance abusers, non-compliant, swearing, and low levels of literacy. Positive descriptors were around attitude and personality (genuine, kind, humorous, honest, polite, understanding, trusting, forgiving, patient). Some registrars described the diversity of their patients (Table 4) and compared how some Aboriginal and Torres Strait Islander patients are higher income earners than medical professionals (Table 4).

Table 4: GP registrars' attitude to Aboriginal and Torres Strait Islander patients

Subtheme	Participant quotes
Non-judgemental, open-minded, kind, and respectful.	I don't think patients expect us to be culturally aware of everything and every possible culture. But I think as long as we're willing to learn, I think patients appreciate that. And I think if you're being honest with patients like 'please feel free to correct me if I'm wrong about your culture or if you feel like I'm saying anything offensive.' I would be happy to correct my words, and I think people would appreciate that. If you're just being honest, if you don't know, then you don't know. (6278) I think the biggest tips and tricks I would say is I guess the simple golden rule is to treat everyone like you want to be treated. (2797)
Expressing their similarities to Aboriginal and Torres Strait Islander patients	So that could be something culturally as well. When I have spoken to them, we also have a very strong cultural framework in which the families are very united. We also call our elders, uncle, and aunties, and they also call everyone uncle and aunties. So, when I have discussed, they have found that this is more closer to what their culture is. (1111)

"Like a human"	I think, treating them like a human being. That's a big thing. I think that no two patients will be the same regardless of their background. And only I guess, only if you absolutely have to ask, you know, about certain things in their history, then then you can bring up the subject. But the biggest thing is that they're not a number. They're a person just like every other person in the world. (3270) I mean, treating them as human. Yeah, I think it's awareness of those communication issues or different communication norms, awareness of history and how that could impact and shape the consult. Letting them run it, making sure I try and avoid as much paternalism as possible. I try and do that for all my patients, not just Aboriginal Australian ones. (4091) I think just be respectful and treat them the same as you would when you're treating non-Aboriginals or family or family friends like you don't treat them any different really, because they're also humans. (6434)
Diversity	Aboriginal Australians come...They're not just one homogenous group, there are all kinds of different people with all kinds of different life experiences, family experiences and cultural norms, which makes it such a diverse group to work with, I find. (4091)

Discussion

A general practice consultation that is culturally safe for Indigenous peoples remains a health goal for Australia and other countries as part of the efforts to address the ongoing disparity in health outcomes for Indigenous peoples (4). Historically, Aboriginal and Torres Strait Islander people have not been permitted to significantly contribute to the determination of cultural safety in healthcare. As such, understanding what characteristics define a culturally safe consultation, particularly as determined by Aboriginal and Torres Strait Islander peoples, is an evolving and developing area of research and discussion. Cultural safety is a complex notion and understanding how registrars view their clinical practice can contribute to narrowing the gap between desired patient/community-defined culturally safe healthcare and the care which is delivered.

This study shows that amongst this small sample, GP registrars want to treat all patients the same and are conscious of not being racist in their practice. However, despite wanting to treat all patients the same, registrars detailed several contradictions to this philosophy. These included:

1. Registrars indicated in the survey that Western models of healthcare may not be suitable to meet the health needs of Aboriginal and Torres Strait Islander peoples but in the interviews did not describe utilising a different model of consultation for patients. Similarly, several registrars indicated in the interview the importance of family in Indigenous culture but in the survey reported that the presence of two or more family members in a consultation is disruptive and should be limited or restricted. Furthermore, it seemed registrars feared offending Aboriginal and Torres Strait Islander patients by asking questions related to their Aboriginality or making eye contact with them. This may indicate that registrars have an awareness of the impact of culture on a patient's health and wellbeing but are not equipped to adapt their consultation approach for distinctive population groups.

2. Registrars seemed to abide by the moral rule of “treat others the way you want to be treated” and failed to recognise that cultural safety should be determined by those being treated, that is, “treat others the way they want to be treated”. This indicates the critical unlearning that needs to occur to progress culturally safe treatment and care.

3. Registrars described seemingly desirable attitudes of being non-judgemental, open-minded, kind, and respectful but this was frequently discordant with registrars’ choice of language when describing Aboriginal and Torres Strait Islander patients. Registrars also did not indicate in interviews the importance of self-reflection or critically examining their own bias, values, and beliefs. Some registrars were very conscious of practising medicine in a way that was not discriminatory or racist but were unconsciously reinforcing structural racism and internalized racial superiority through a deficit and “othering” approach. Registrars may have been trying to be use the word “humans” as inclusive language. However, use of the metaphor and simile to state “treating them like/as a human” implies that registrars are treating Aboriginal and Torres Strait Islander patients as subhuman. Registrars also recognised power imbalances and tried to address these in practice by simplifying language and reducing height imbalance but at the same time minimised differences and power differential by focussing on their similarities with Aboriginal and Torres Strait Islander peoples.

This study suggests we need to develop a model of cultural safety training for GP consultations within the Australian context where cultural safety is defined by the Aboriginal and Torres Strait Islander community. Registrar transformative learning and unlearning needs to occur to shift attitudes and action to impact on the health and wellbeing of Aboriginal and Torres Strait Islander peoples. For example, there are many traditional teachings and folklore in Indigenous healthcare delivery in Australia that tend to homogenise a diverse population and reinforce stereotypes. These include aspects of practice such as avoiding eye contact, providing plenty of silence, and ensuring family are included in consultations. Changing or adapting this narrative and discerning the difference between what patients need and want, and how registrars deliver care, will shape healthcare education and training for registrars. In this study we did not aim to explore if Aboriginal and Torres Strait Islander GP registrars treat Indigenous and non-Indigenous patients the same. The Aboriginal and Torres Strait Islander registrars drew on their lived experience when describing health care and their delivery of care.

This study is part of a larger research project that includes exploring a culturally safe consultation from the patient's perspective and how to assess cultural safety in a GP consultation (17). In developing this assessment, we need to consider a model of care where all patients are not treated the same but distinctively different considering their historical, political, and social determinants of health and their individual body, mind and emotions, family and kinship, community, culture, country and spirituality and ancestors (12).

Strengths and Limitations:

This mixed-methods study allowed comparison of survey and interview data to better understand registrars and how they considered Indigenous health. The in-depth qualitative data collected provides insight to this sample's perceptions of cultural safety. At 16 interviews, analysis suggested that no new insights were being generated and thematic saturation had been reached. The sixteen registrars who were interviewed were from diverse backgrounds including Aboriginal and Torres Strait Islander doctors and international medical graduates. The small sample of GP registrars were in one Australian state across a broad geographic region covering many different traditional Aboriginal and Torres Strait Islander nations.

This study relied on registrar self-assessment and self-reporting and did not attempt to measure registrar insight. Voluntary or self-selection response bias also suggests participants with an interest in Indigenous health and cultural safety were more likely to participate in the study. As such, non-participating registrars are likely to have a greater deficit in understanding culturally safe care than participating registrars. Many registrars had limited experience with Aboriginal and Torres Strait Islander patients and as such this dichotomy may reflect social desirability bias (what registrars considered would be favourably viewed by the researchers and the Aboriginal and Torres Strait Islander population) and their academic learnings throughout their medical school and university training, rather than actual belief and clinical practice. This may also reflect that registrars have difficulty translating cultural safety training into practice and instead revert to familiar practice. Furthermore, the practicing behaviour of participating registrars may be quite different to what is reported, as demonstrated by the adapted Miller's pyramid of clinical competency (doesn't know/needs to know / unknown through to does and professional identity) and is worthy of further research (8). We also query whether Aboriginal and Torres Strait Islander registrars adapt different styles when consulting with Indigenous or non-Indigenous patients.

Conclusion

This study suggests that overall, GP registrars want do improve the health of Aboriginal and Torres Strait Islander patients, but do not want their consultations with Aboriginal and Torres Strait Islander patients to be distinctive. Registrars appeared to approach all consultations in a similar manner using predominantly patient-centred care principles. Given the importance of a culturally safe consultation, it is important for us to consider how to increasingly transform these learners and teach cultural safety in this context.

Declarations

Ethics approval and consent to participate:

The James Cook University Human Research Ethics Committee approved this study (H8296) following review by Aboriginal and Torres Strait Ethics Advisors in accordance with the National Health and Medical Research Council guidelines.

Consent for publication: Not applicable.

Availability of data and materials: The datasets analysed during the current study are not publicly available due to participants being potentially identifiable from the small dataset but are available from the corresponding author on reasonable request.

Competing interests: Nil

Funding: This project has received funding through an Australian College of Rural and Remote Medicine: 2022 Education Research Grant.

Authors' contributions:

KB conceptualized and led the design of the project, analysed, and interpreted the registrar data, and was the major contributor in writing the manuscript.

HW, RE, HN, TS, LM and RW contributed to co-design of the project, data analysis and drafting and revision of the manuscript.

All authors approved the manuscript for publication.

Acknowledgements: Kerrilee Gow who managed the project and undertook data collection, the Community advisory panel for supporting and overseeing the research project.

References

1. Royal Australian College of General Practitioners. RACGP Educational framework. Melbourne: RACGP; 2020 [Available from: https://www.racgp.org.au/education/registrars/fellowship-pathways/racgp-educational-framework/acknowledgments.

2. Delaney L. Patient-centred care as a approach to improving health care in Australia. Collegian. 2018; 25:119-23.

3. Australian Commission on Safety and Quality in Health Care. Patient-centred care: Improving quality and safety through partnerships with patients and consumers. Sydney: 2011. p. 104.

4. Ahpra & National Boards. The National Scheme’s Aboriginal and Torres Strait Islander health and cultural safety strategy 2020-2025. Canberra: Ahpra and National Boards; 2020.

5. Morgan S, Chan M, Starling C. Starting off in general practice - consultation skill tips for new GP registrars. AFP. 2014; 43(9):645-8.

6. Silverman J, Kurtz S, Draper J. Skills for Communicating with Patients. Radcliffe Medical Press (Oxford). 1998.

7. Neighbour R. The inner consultation: how to develop an effective and intuitive consulting style. 2nd ed. Oxford: Radcliffe Medical Press; 2004.

8. Pendelton D, Schofield T, Havelock P. The consultation: an approach to teaching and learning. Oxford: Oxford University Press; 1984.

9. Murtagh J, Rosenblatt J, Murtagh C, Coleman J. Murtagh general practice. 8th ed. Australia: McGraw Hill; 2021.

10. Pitama S, Bennett S, Waitoki W, Haitana T, Valentine H, Pahina J, et al. A proposed Hauora Māori clinical guide for psychologists: using the Hui Process and Meihana Model in clinical assessment and formulation. New Zeal J Psychol. 2017;46(3):7-19.

11. McKivett A, Paul D, Hudson N. Healing conversations: developing a practical framework for clinical communication between Aboriginal communities and healthcare practitioners. J Immigr Minor Health. 2019;21(3):596-605.

12. Gee G, Dudgeon P, Schultz C, Hart A, Kelly K. Social and emotional wellbeing and mental health: an Aboriginal perspective. In: Dudgeon P, Milroy M, R W, editors. National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017-2023. Revised ed. Canberra: Department of Prime Minister and Cabinet: Commonwealth of Australia; 2017. p. 55.

13. Grant J, Parry Y, Guerin P. An investigation of culturally competent terminology in healthcare policy finds ambiguity and lack of definition. Aust N Z J Public Health. 2013;37(3):250-6.

14. Paul D, Hill S, Ewen S. Revealing the (in)competency of "cultural competency" in medical education. AlterNative. 2012;8(3).

15. Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee. Cultural respect framework 2016-2026. Adelaide: Australian Health Ministers' Advisory Council; 2016.

16. AHPRA & National Boards. A consistent baseline definition of cultural safety for the National Scheme. Canberra2019.

17. Brumpton K, Ward R, Evans R, Neill H, Woodall H, McArthur L, et al. Assessing cultural safety in general practice consultations for Indigenous patients: protocol for a mixed methods sequential embedded design study. BMC Medical Education. 2023;23(1):306.

18. West R, Wrigley S, Mills K, Taylor K, Rowland D, Creedy D. Development of a First Peoples-led cultural capability measurement tool: a pilot study with midwifery students. Women Birth. 2017; 30(3):236-44.

19. Ryder C, MacKean T, Ullah S, Burton H, Halls H, McDermott D, et al. Development and validation of a questionnaire to measure attitude change in health professionals after completion of an Aboriginal health and cultural safety training programme. Australian Journal of Indigenous Education. 2019;48(1):24-38.

20. Erlingsson C, Brysiewicz P. A hands-on guide to doing content analysis. African Journal of Emergency Medicine. 2017;7(3):93-9.

21. Royal Australian College of General Practitioners. Standards for general practices. 5th edn. East Melbourne: RACGP; 2020.

Figure Legend:

Figure 1 – Cultural capability measurement and attitude as self-reported by GP registrars.

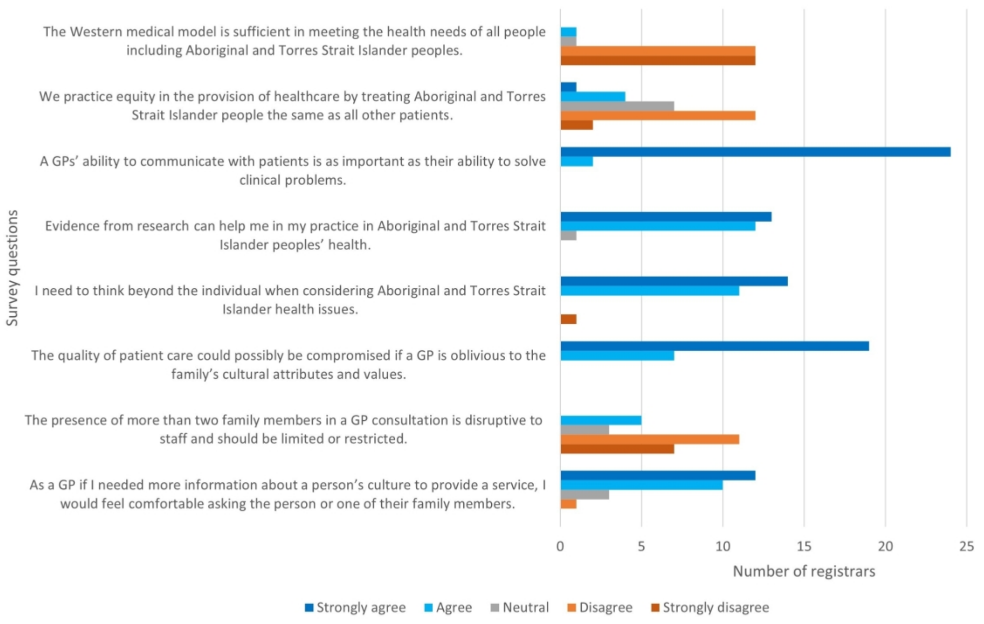


Figure 1: Cultural capability measurement and attitude as self-reported by GP registrars.

Figure 1: Cultural capability measurement and attitude as self-reported by GP registrars.

208x145mm (330 x 330 DPI)

Survey and Interview Guide for GP registrars.

Survey for GP registrars:

1.Which category includes your age?

18-24
25-34
35-44
45-54
55-64
65+

2.What is your gender?

Male
Female
Other

3.Which category best describes the number of years you are post-graduate from medical school?

1-4
5-7
8-10
11-15
16-20
21-25
> 25

4.Which of the following categories best describes your general practice position?

Intern or resident
AGPT registrar
Non-AGPT registrar
Non-VR General practitioner
Vocationally registered general practitioner

4a. What college are you training with or hold fellowship with?

RACGP
ACRRM
Both
Don’t know
Not applicable

4b. What is your current stage of GP training?

Hospital / Core generalist
First year GP training
Second year GP training
Advanced skill training

4c. What university did you complete your medical degree through?

James Cook University
Griffith University
University of Queensland
Bond University
Other Australian University: _______________
Overseas University: ________________
Prefer not to say

4d. My medical degree was:

Undergraduate
Post-graduate – Yes, progress to 4e

4e. What was your undergraduate degree: __________

4f. What is the nature of your current main practice? (Choose all that apply).

Hospital based
General practice based
Aboriginal Health or Medical Service
Other

4g. What is the postcode of your current main workplace?________

5.How long have you lived in Australia?

0- 5 years

6-10 years
11-15 years
>15 years
All of my life

6.During your practicing career, approximately how much time have your worked in a setting with mostly Aboriginal and Torres Strait Islander patients?

Nil
<6 months
7-12 months
1-3 years
4-6 years
7-10 years
11-15 years
16-20 years
21-25 years
> 25 years

Questionnaire for GP registrars:

Item	Item definition
CST*Q1	I think my beliefs and attitudes are influenced by my culture.
CSTQ2	A GPs' own cultural beliefs influence their health care decisions.

CSTQ3	Time in the GP curriculum devoted to the promotion of * self-awareness and well-being is time well spent.
CSTQ4	A GPs' ability to communicate with patients is as important as their ability to solve clinical problems.
CSTQ5	The presence of more than two family members in a GP consultation is disruptive to staff and should be limited or restricted.
CSTQ6	The quality of patient care could possibly be compromised if a GP is oblivious to the family's cultural attributes and values.
CSTQ7	As a GP if I needed more information about a person's culture to provide a service, I would feel comfortable asking the person or one of their family members.
CSTQ8	Aboriginal and Torres Strait Islander people, due to the own cultural beliefs and values, have the poorest health status in Australia.
CSTQ9	Aboriginal and Torres Strait Islander people, should be responsible for improving their own health.
CSTQ10	The Western medical model is sufficient in meeting the health needs of all people including Aboriginal and Torres Strait Islander peoples.
CSTQ11	All Australians need to understand Aboriginal and Torres Strait Islander history and culture.
CSTQ12	Aboriginal and Torres Strait Islander people should not have to change their culture just to fit in.
CSTQ13	We practice equity in the provision of healthcare by treating Aboriginal and Torres Strait Islander people the same as all other patients.
CSTQ14	I need to think beyond the individual when considering Aboriginal and Torres Strait Islander health issues.
CSTQ15	I have a social responsibility to work for changes in Aboriginal and Torres Strait Islander health.
W*1	History does not impact on Aboriginal and Torres Strait Islander health.
W2	Understanding Aboriginal and Torres Strait Islander peoples' history will inform my practice as a GP.
W3	Understanding Aboriginal and Torres Strait Islander peoples' social practices will not apply to my practice.
W4	I find it difficult to understand the beliefs of different cultural groups.
W5	Evidence from research can help me in my practice in Aboriginal and Torres Strait Islander peoples' health.
W6	Aboriginal and Torres Strait Islander peoples receive unnecessary special treatment from government.

CST* – selected questions from Ryder et al (1) measure of attitude change.
W* – selected questions from West et al (2) cultural capability measurement tool.

(Modifications to original surveys:
Throughout the survey the term:
- health professional is replaced with GP throughout the survey.
- Aboriginal people is broadened to Aboriginal and Torres Strait Islander people
- patient is used instead of client

CSTQ3 - *the word student is deleted
CSTQ5 – "GP consultation" used instead of "hospitalised patient's room". "Prohibited" replace with "limited or restricted".
CSTQ9 – Modified from "should take more individual responsibility" to "should be responsible"
W6 – Unnecessary added)

Interview Guide GP registrars exploring what is distinctive to consultations with Aboriginal and Torres Strait Islander patients

Note: If registrars have not commenced GP training or have not consulted any Aboriginal and Torres Strait Islander patients the wording in brackets may be substituted.

To start this interview, could you please tell me why do you think Aboriginal and Torres Strait Islander patients choose (would choose) to see you as their doctor?

Can you describe Aboriginal and Torres Strait Islander patients for me please?

Prompt: Tell me about your Aboriginal and Torres Strait Islander patients. What are they like? Do you feel they are different to your non-Indigenous patients?

What are the most important things you do (could do) to make Aboriginal and Torres Strait Islander patients feel culturally safe when you are consulting?

What is (would be) your communication strategy in consultations with Aboriginal and Torres Strait Islander patients?

Probe: How do you start your consultation with Aboriginal and Torres Strait Islander patients?

How do you (would you) describe your consultation approach to Aboriginal and Torres Strait Islander patients?

Do you (would you) use a particular model of consultations?

Do you modify this model in any way for Aboriginal and Torres Strait Islander patients?

Is this different to your approach with patients who do not identify as Aboriginal and Torres Strait Islander?

How do you provide emotional support for your Aboriginal and Torres Strait Islander patients?

Can you describe a time when you feel a patient may have felt culturally unsafe when you were consulting?

Can you describe any occasions when your felt uncomfortable with your Aboriginal and Torres

Strait Islander patients?

What does a culturally safe GP consultation look like to you?

How do you demonstrate respect for your Aboriginal and Torres Strait Islander patients?

On a scale of 1-5, how important are the following when consulting with Aboriginal and Torres Strait Islander patients:

The inclusion of spirituality

Including family, elders, or significant others

The use of silence

Eye contact

Your knowledge of Australia pre-colonisation

Your knowledge of the experiences of Aboriginal and Torres Strait Islander people after colonisation

Your medical/clinical knowledge and skills

Learning and using some traditional language

On a scale of 1-5, how important is:

Your culture to you and your identity

Connection to land

What tips/tricks/words of wisdom would you like to give to medical students to improve the way they consult with Aboriginal and Torres Strait Islander patients?

Do you have anything else you want to add?

References:

1. Ryder C, MacKean T, Ullah S, Burton H, Halls H, McDermott D, et al. Development and validation of a questionnaire to measure attitude change in health professionals after completion of an Aboriginal health and cultural safety training programme. Australian Journal of Indigenous Education. 2019;48(1):24-38.

2. West R, Mills K, Rowland D, Creedy DK. Validation of the first peoples cultural capability measurement tool with undergraduate health students: a descriptive cohort study. Nurse Educ Today. 2018;64:166-71.

No.	Description of the standard	Page number
#1	Title: Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	2
#2	Abstract: Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusion	2
#3	Problem formulation: Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	4-5
#4	Purpose of research question: Purpose of the study and specific objectives or questions	5
#5	Qualitative approach and research paradigm: Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale*	6
#6	Researcher characteristics and reflexivity: Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	7
#7	Context: Setting/site and salient contextual factors; rationale**	6
#8	Sampling strategy: How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale	6
#9	Ethical issues pertaining to human subjects: Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security is	20
#10	Data collection methods: Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	6
#11	Data collection instruments and technology: Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	6
#12	Units of study: Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	7
#13	Data processing: - Methods for processing data prior to and during	7

	analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	
#14	Data analysis: - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	7
#15	Techniques to enhance trustworthiness: - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale*	6
#16	Synthesis and interpretation: Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	7
#17	Links to empirical data: Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic finding	7-18
#18	Integration with prior work, implications, transferability, and contribution(s) to the field: Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	18
#19	Limitations: Trustworthiness and limitations of findings	2-3
#20	Conflicts of interest: Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	20
#21	Funding: Sources of funding and other support; role of funders in data collection, interpretation, and reporting	21