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

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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 semistructured interviews.

Results 26 registrars completed the survey. 16 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 to 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 practising 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 *et al*'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 well-being, 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 *et al* have 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 well-being 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-methods 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 semistructured 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 file 1 survey and interview guide). Participants provided written informed consent.

Data analysis

Survey data were 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, practising behaviours (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 (A1) 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 2 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 min of audio-recording was analysed. The median length of interviews was 33.4 min with the longest interview 95 min and the shortest 18 min.

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.

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).

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 healthcare 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

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 vs 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)

GP, general practitioner.

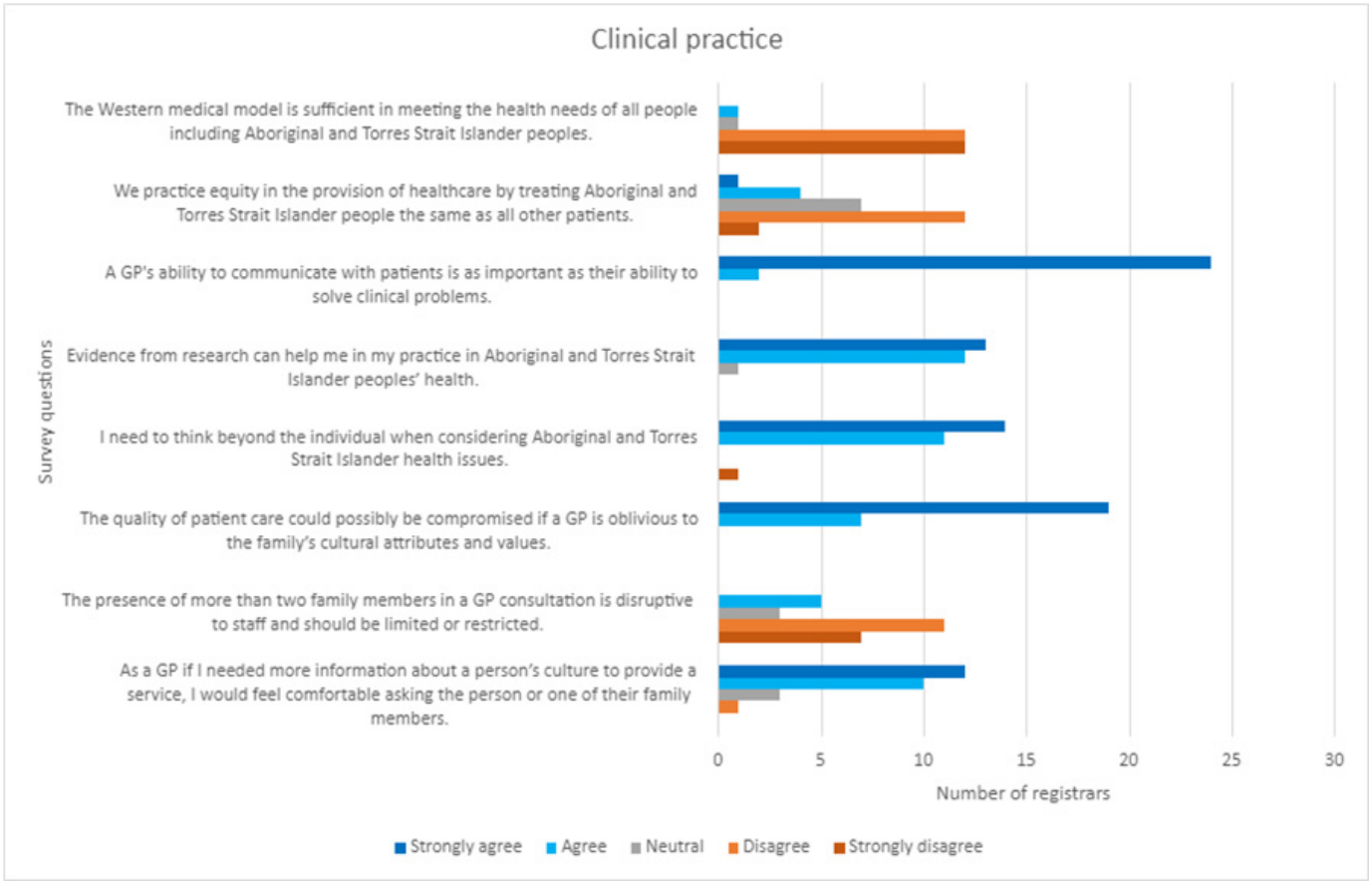

Figure 1 Cultural capability measurement and attitude as self-reported by GP registrars. GP, general practitioner.

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 well-being such as connection to community, family and kinship, mind and emotions, or spirituality.

Theme 2: demonstration of cultural safety

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

Communication skills (non-verbal and verbal)

Registrars described demonstrating culturally safe care through focusing 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

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)

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 socioeconomic status that they would not be affected by colonial failings.

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 registrars' 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

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)

GP, general practitioner.

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).

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 and 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).

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

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)

GP, general practitioner.

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 among 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 using 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 well-being 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 internalised 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 focusing 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 well-being 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 healthcare 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 provide insight into 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 16 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 geographical 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 learning 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 practising 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 to 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.

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Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by the James Cook University Human Research Ethics Committee (H8296). Participants gave informed consent to participate in the study before taking part.

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