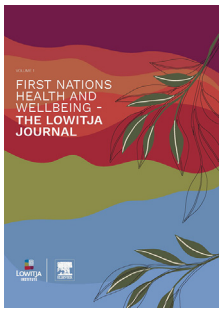

Original Research

Racism and cultural safety for Indigenous general practice trainees: An exploratory study of how to support training, careers and professional wellbeing

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Abstract

Purpose Racism as a social determinant of health has known impacts on the physical and mental health of Indigenous peoples, which extends to Indigenous doctors in training and is a barrier to the growth of the Indigenous health workforce in Australia. This study aimed to explore racism and cultural safety within the professional experiences of Australian Indigenous general practice (GP) trainees, to elucidate barriers and facilitators to their training, careers and professional wellbeing.

Methods A sequential exploratory mixed methods study was conducted in 2020 and 2021 through an initial quantitative online administered questionnaire followed by qualitative semi-structured interviews with Indigenous GP registrars, from either metropolitan or rural areas, undertaking GP training in Australia. The main outcome measures included online responses to the Measure of Indigenous Racism Experiences (MIRE) questionnaire, which measures several dimensions of racism, and data from thematic analysis of semi-structured interviews undertaken following the online questionnaire.

Main findings The MIRE questionnaire responses revealed experiences of racism across multiple levels. These findings were integrated and expanded with the central themes drawn from the interviews. Themes focused on GP training and training environments and operated across interactions with peers, supervisors and patients. The identified themes were i) cultural identity, with the subthemes of professional wellbeing

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and professional goals and identity; ii) training challenges, including racism and career development; and iii) training facilitators, including specific support and mentorship.

Principal conclusions Australian Indigenous GP trainees value their cultural identity in relation to their professional goals and wellbeing. However, challenges for trainees centre around the lack of cultural safety and presence of racism, which is pervasive across their professional life. Strategies to address this could include further provision of specific support, specific culturally safe training placements, networking and mentorship.

Keywords: Racism; Indigenous Australian; General practice training; Professional wellbeing; Cultural safety

Highlights

- Australian Indigenous general practice trainees value their cultural identity in relation to their professional goals and wellbeing.
- Challenges for trainees centre around the lack of cultural safety and presence of racism, which is pervasive across their professional life.
- Strategies to address this could include further provision of specific support, specific culturally safe training placements, networking and mentorship.

Introduction

Racism as a social determinant of health has emerged as an increasingly recognised issue impacting the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples (Paradies 2006a) – hereon referred to as Indigenous peoples but recognising the diversity of this group – and is important in healthcare settings due to its effects on the physical and, especially, mental health of Indigenous peoples (Durey and Thompson 2012; Kairuz et al. 2021; Paradies 2006b). Racism can be defined as societal systems that cause inequalities and manifests through beliefs, stereotypes, prejudices or discrimination via multiple means including internalised, interpersonal and systemic levels (Paradies 2006b) and affects other health determinants, such as socioeconomic status (Jones 2000). In the Australian setting, the published literature regarding impacts of race on medical professionals largely focuses on medical students' experiences and recruitment, with limited research on the experiences of Indigenous doctors regarding racism. Therefore, there is a need to explore the experiences of Indigenous medical professionals across their careers, including the impact of systemic pressures affecting training and career progression (Bond et al. 2019).

In Australia, one of the key strategies for 'Closing the Gap' for Indigenous peoples is increasing the Indigenous health workforce; however, the ill-effects of racial discrimination are a recognised barrier for retention and growth of this sector (Australian Indigenous Doctors Association 2017). The National Aboriginal and Torres Strait Islander Health Plan recognises racism as a key social determinant of health and argues that increasing the Indigenous workforce is pivotal to engaging Indigenous patients, developing and maintaining culturally safe workplaces,

and addressing institutionalised racism (Commonwealth of Australia 2013; Deroy and Schütze 2019). The Royal Australian College of General Practitioners (RACGP) adopts a zero tolerance policy to racism and advocates for practice and training environments that are free from discrimination, but acknowledges racism as a barrier for Indigenous peoples joining the medical workforce (Royal Australian College of General Practitioners 2018).

Despite these sentiments, bullying, harassment and discrimination occurred at higher rates in Indigenous general practice (GP) respondents of the 2021 Medical Training Survey compared with non-Indigenous respondents (Ahpra 2021). Racism and bullying often started early in their medical careers (Beyond Blue 2013), with Aboriginal medical students experiencing the impacts of racism on their perception of self as a minority in the hospital setting, having reduced confidence and feeling the need to justify their position, while managing negative expectations from teachers and peers (Garvey et al. 2009). Indigenous medical professionals may conceal their identity due to discrimination, avoidance and exclusion, stereotyping and racist comments in the workplace (Australian Indigenous Doctors Association 2017). Further factors associated with health students leaving their degree include a deficiency of support networks, internal stressors such as reduced confidence, racism and discrimination, lack of cultural safety, and course and curriculum characteristics that have a dearth of Indigenous content and approaches (Taylor et al. 2019). International evidence regarding racial minority in health professionals highlights racial stereotyping, discrimination, self-doubt, internalised racism and lack of diversity in medical training as inhibitors to success and career progression (Claridge et al. 2018; Esmail 2013; Iacobucci 2020; Johansson et al. 2011; Liebschutz 2006; London 2009; Odom 2007). Racial minority GP trainees in the United Kingdom (UK) show significant differences in passing clinical skills assessments, despite comparable marks on written examinations, which may be attributable to multiple reasons including subjective bias, subtle racial discrimination, and reduced diversity of examiners and patient actors (Esmail 2013).

Conversely, race and cultural identity can have positive impacts for Indigenous medical students in the form of personal and cultural support, role models and mentors (Garvey et al. 2009). Additionally, Indigenous doctors' cultural identity positively impacts their approach towards colleagues and patients, with increased compassion, empathy and holistic relationships (Australian Indigenous Doctors Association 2017). Bond et al. (2019) recognise the way that Indigenous medical professionals influence and experience their workplaces after graduation, which can lead to transformation of power and racial dynamics within healthcare systems.

Efforts in recruitment and retention of Indigenous peoples into the medical profession have reduced the focus on the impact of racism and the professional experiences of Indigenous doctors, specifically GP trainees. Supporting an Indigenous health workforce is vital and may promote a deeper understanding of how race currently operates within the health system and assist in addressing health inequities (Bond et al. 2019). Elucidating these experiences will identify areas for improvement along with systemic changes that need to be implemented in support of GP trainees. Therefore, this study aimed to explore Indigenous GP trainees' experiences of racism using a mixed methods approach to provide insight into these racialised experiences, with a focus on the associations with training, careers and professional wellbeing.

Methods

Study design

This exploratory sequential mixed methods study used quantitative data from an online survey that included demographic questions and the validated 31 item questionnaire Measure of Indigenous Racism Experiences (MIRE) (Paradies 2008), which measures several dimensions of racism, related stressors and responses to racism using Likert scales. The online survey was followed by qualitative semi-structured interviews with respondents who opted into the interview portion of the study. The study design was consistent with others exploring racism and Indigenous medical professionals' experiences, and experiences of racial minority doctors internationally (Australian Indigenous Doctors Association 2017; Beyond Blue 2013; Larson et al. 2007; Liebschutz 2006; London 2009; Marcella 2007; Paradies 2015). The semi-structured interview questions were formulated from the existing literature exploring experiences of race on minority medical trainees (Liebschutz 2006; London 2009; Marcella 2007); the questions that were posed (Supplementary Table) were 'theoretically' grounded and 'contextually' based in the sense that narrative experiences were explored within the context of operative societal influences (Braun and Clarke 2006). Outcome measures included those utilised by the MIRE as described by Paradies (2008), which are underpinned by the key domains of racism, including interpersonal, internalised and systemic racism, along with race consciousness (Supplementary Table). Quantitative data consisted of demographic data, including age, sex and mode of GP training delivery (rural vs. metropolitan, part time vs. full time) along with the racism questionnaire. The link to the survey was distributed via the recruitment flyer. Qualitative data came from interviews, which focused on medical and specialist training, including workplace experiences, interactions with patients, interactions with work colleagues and peers, career planning and support systems. Interviews conducted by author TM in late 2020 and early 2021 occurred via telephone or videoconferencing software and were recorded and transcribed verbatim by author TM after each interview prior to deletion.

Study participants and setting

Australian Indigenous GP registrars, including metropolitan or rural trainees, undertaking a GP training program were recruited nationally. General practitioner training is commenced after two post-graduate hospital years and comprises a further 2 years of specialised training. Participants were recruited from any level of training, including the post-training term for candidates who are eligible to gain their final qualification titled 'awaiting Fellowship'. The potential population size from which to obtain a study sample was low at approximately 90, based on reporting that showed there were 63 self-identified enrolled Indigenous trainees registered with the RACGP in 2020-2021 (Royal Australian College of General Practitioners 2021). The number of trainees enrolled and identified with the Australian College of Rural and Remote Medicine (ACCRM) was 27 (Australian Indigenous Doctors Association 2020). Purposeful sampling was undertaken through email flyer advertising via registrar mailing lists held by the RACGP, ACCRM, regional training organisations who assist in delivering training in various Australian jurisdictions and general newsletter mailing lists held by the Australian Indigenous Doctors Association (AIDA). Demographic data for the 11 online questionnaire participants are outlined in Table 1.

This research was undertaken with a cohort of Indigenous peoples in Australia. Ethical principles and concerns were considered in the context of the

MIRE outcome measure	Related interview questions	Themes from integration
Interpersonal Racism	How do you think race influences your experiences at work? Can you think of a negative work-related experience since commencing your GP registrar or medical training you had that was attributed to race? Tell me about that experience. Have you been treated differently during your GP registrar or medical training due to your racial background? Can you think of a positive work-related experience, since commencing your GP registrar or medical training, you had that was attributed to race? Tell me about that experience.	Training Challenges: Racism and Workplace Cultural Safety Training Facilitators: Specific supports, Mentorship and Networks
Adaptive and Maladaptive responses to Racism	Have you ever experiences racism from a patient? Tell me about this experience. How have your experiences impacted any of the following? - Interactions with work colleagues and peers? - Interactions with patients?	Cultural identity: Professional Wellbeing
Internalised and systemic racism	Have you been treated differently during your GP registrar or medical training due to your racial background? Is there anything further you would like to tell me about the effects of race on your work-related or training-related experiences?	Training Challenges: Racism and Workplace Cultural Safety Training Facilitators: Specific supports, Mentorship and Networks
Race-consciousness	How do you think race influences your experiences at work?	Cultural identity: Professional goals and identity
Ethnoracial identity within their social group	How has race and your experiences during training influenced your career path (s)?	Cultural identity: Professional goals and identity Training Facilitators: Specific supports, Mentorship and Networks
Salience of a respondent's ethnoracial identity among strangers	How has race and your experiences during training influenced your career path (s)?	Cultural identity: Professional goals and identity Training Facilitators: Specific supports, Mentorship and Networks

Table 1: Utilising Wooley's integrated approach for thematic analysis for integration of survey and qualitative data supporting the themes

National Health and Medical Research Council (NHMRC) Guidelines for Research in Aboriginal and Torres Strait Islander Peoples and Communities (NHMRC 2018). These ethical principles were applied to each stage of study design, recruitment, consent and data collection, de-identification and storage. The sensitive nature of the topic meant that the potential emotional impact on participants had to be considered, and all participants were provided with written information about free medical professional-specific counselling services and support available if needed. In addition, interviews were conducted by an Indigenous GP trainee (TM) to enable a safe interview process aligned with other qualitative studies where racially concordant interviewers were utilised (Claridge et al. 2018; Garvey et al. 2009; Paradies 2008). Key stakeholders such as RACGP, AIDA and the Indigenous General Practice Registrars Network were informed and consulted about the project prior to ethics submission and approval, and this informed the study design. In addition, AIDA and RACGP assisted with recruitment through advertisement of the study within their networks. Ethics approval was granted by the Western Australian Aboriginal Health Ethics Committee and the University of Western Australian Ethics Committee.

Analysis

Analysis used a mixed methods approach integrating quantitative data from the validated MIRE questionnaire and demographic information for the

11 participants who undertook the online portion of the study, along with qualitative data from semi-structured interviews undertaken with three participants. As described by Wooley, this integrated approach (Woolley 2009) is effective in enhancing the understanding of the quantitative information acquired through the online component by application of cross-comparison with the qualitative data, as shown in Table 1, and was considered the best approach to understand the measure of racism that these junior doctors had experienced, as well as to provide greater understanding of these experiences within their training context.

Interviews were analysed using thematic analysis with a contextualist approach outlined by Braun and Clarke (2006) and assessed independently by the authors (TM and JF) for important and emergent themes. Transcription of audio recordings was undertaken by TM and this allowed initial familiarisation with data, as recommended by Braun and Clarke (2006), and formulation of initial themes after each interview. Salient themes and subthemes from interviews were continually confirmed after each interview until no new themes emerged when contextualised and re-evaluated with the entire data set (Braun and Clarke 2006), and it was then considered that data saturation was reached. Data saturation was supported by the extended length of each interview, which lasted 35 (P1), 39 (P1) and 79 (P3) minutes. Further, a deductive approach was applied to explore existing theories surrounding race (Paradies 2006a) and existing evidence regarding the impact of race on racial minority and Indigenous doctors.

Interviews were coded using NVivo version 1.5 (QSR International), according to themes and data items that were categorised under headings that grouped items that were salient with the research question. Themes were reintegrated with quantitative MIRE questionnaire data for internal validation of themes related to racialised experiences and enhancement of realised results (Woolley 2009). Quantitative data were entered into SPSS version 27 (IBM Corp, Armonk, NY, USA) with frequency analyses performed on participant responses to the MIRE questionnaire. Demographic data were collated for each participant as outlined in Table 1. Due to the small sample size, analysis of differences in responses to the MIRE questionnaire based on gender, age, training location and training level was not performed.

Results

The experiences of racism for trainees were generally multilevel and embedded across the central themes drawn from the interviews and evident in the online responses to the MIRE questionnaire. The demographic data for the 11 participants for the online component of the study are presented in Table 2. The responses to the MIRE questionnaire from the 11 participants are reported in Table 3 and summarised in the relevant sections under each theme below. Themes focused on GP training and training environments, and operated across interactions with peers, supervisors and patients. The identified themes were i) cultural identity, with the subthemes of professional wellbeing and professional goals and identity; ii) training challenges, including racism and career development; and iii) training facilitators, including specific support and mentorship.

Cultural identity – professional wellbeing and professional goals and identity

Cultural identity was important for professional wellbeing and in shaping professional identity. A high level of race consciousness was detected for the online questionnaire participants, with the majority reporting thinking about being Indigenous once per day or constantly. In addition, regarding ethnoracial

Number of participants	% (*n* = 11)
Gender	
Male	36.4% (4)
Female	63.6% (7)
Age	
25–34	27.3% (3)
35–44	45.5% (5)
45 +	27.3% (3)
Level of training*	
GPT1	18.2% (2)
GPT2	27.3% (3)
GPT3	18.2% (2)
ES	9.1% (1)
AF/RF	27.3% (3)
Training pathway	
Rural	27.3% (3)
Metropolitan	72.7% (8)
Training delivery	
Part time	45.5% (5)
Full time	54.5% (6)

Data are shown as % (*n*). *GPT1: GP training term 1 (first 6 months of community-based GP training). GPT2: GP training term 2 (second 6 months of community-based GP training). GPT3: GP training term 3 (third 6 months of community-based GP training). ES = Extended Skills: Elective general practice training term (hospital or community based). AF/RF = Awaiting Fellowship/recent Fellow: Has completed all general practice training requirements and awaiting or has been appointed their Fellowship qualification.

Table 2: Demographic information of survey participants

identity generally, all participants identified that they felt 'good about being Indigenous'. This was further explored in the interviews, when participants spoke about the positive impact of identifying as Indigenous in their medical role.

> *For the most part non-Indigenous patients are happy and supportive when they have an Indigenous doctor* (P1, female, recent Fellow, metropolitan, part time).

Participants discussed the way their Indigenous identity positively impacts engagement with Aboriginal patients:

> *And she cried when I was speaking language and it was like a happy surprise and she had the biggest grin on her face* (P3, female, GPT1, rural, full time).

However, conflict about disclosing their cultural identity was sometimes reported, which relates to the MIRE construct of ethnoracial identity among strangers. This was emphasised in responses to the related MIRE questionnaire item 'Do people you meet for the first time know that you are Indigenous?'. In relation to this question, six participants responded 'No, hardly anybody' or 'No, not many people'. This internal conflict was further expanded in the interviews:

> *On the flip side dealing with Aboriginal patients... Sometimes I felt like I – aw like should I say you know actually I am an Aboriginal GP – make them feel more comfortable – or would that make them feel [uncomfortable]?* (P1, female, recent Fellow, metropolitan, part time).

This became increasingly difficult when navigating challenges of extended family or advocating for Indigenous patients:

> *...who do I treat at the hospital and who don't I treat, and how do I get around that, how to navigate... family members and my role in... advocating* (P2, male, GPT1, rural, full time).

There was recognition of increased pressures with obligation, and a sense of responsibility and being treated differently by other staff, which relates to all racialised experience constructs explored in the MIRE questionnaire.

> *I really struggled with that... when you're labelled as an Aboriginal medical student there's a lot of responsibility that comes with that and I don't think I really understood that... properly when I... applied* (P1, female, recent Fellow, metropolitan, part time)
>
> *I'm the first Aboriginal doctor that they've [work colleagues] ever worked with and I think that for them it was confronting on many levels because it was*

Question: How often are you treated unfairly because you are Indigenous in each of the following situations? (If the situation doesn't apply to you, please tell me)
Outcome measure: Interpersonal racism

	Never	Hardly ever	Sometimes	Often	Very often	Doesn't apply
At work or on the job	27	36.4	18.2	18.2	0	0
At home, by neighbours or at somebody else's house	18.2	54.55	27.3	0	0	0
At school, university or other academic setting	0	27.3	54.5	9.1	9.1	0
While doing sporting, recreational or leisure activities	36.4	54.5	9.1	0	0	0
By the police, security personnel, lawyers or in a court of law	27.3	45.5	18.2	0	0	9.1
By doctors, nurses or other staff at hospitals or doctors' surgeries	9.1	27.3	54.5	9.1	0	0
By staff of government agencies like Centrelink, etc.	36.4	36.4	27.3	0	0	0
By staff at restaurants, bars, shops, banks, motels, real estate agents, in taxis or when getting any other services	18.2	63.6	9.1	9.1	0	0
By other people on the street, at shopping centres, sporting events, concerts, nightclubs etc	18.2	45.5	36.4	0	0	0
By other indigenous people	36.4	27.3	27.3	9.1	0	0

Question: When you are treated unfairly because you are Indigenous how often do you:
Outcome measure: Adaptive and maladaptive responses to racism

	Never	Hardly ever	Sometimes	Often	Very often
Ignore it, forget about it or accept it as a fact of life	0	0	45.6	36.4	18.2
Try to avoid it in the future	0	0	36.4	45.5	18.2
Try to change the way you are or things that you do so that it won't happen again	18.2	9.1	45.5	27.3	0
Try to do something about the people who did it or the situation in which it happened	0	45.6	45.6	9.1	0
Talk to other people like family or friends about it, or write, draw, sing or paint about it	9.1	9.1	36.4	27.3	18.2
Keep it to yourself	9.1	9.1	36.4	27.3	18.2
Feel ashamed, humiliated, anxious or fearful	9.1	18.2	36.4	27.3	9.1
Feel angry, annoyed or frustrated	0	0	45.5	36.4	18.2
Feel amused, contemptuous or sorry for the person who did it	36.4	18.2	45.5	0	0
Feel powerless, hopeless or depressed	18.2	18.2	45.5	0	0
Get a headache, an upset stomach, tensing of your muscles, or a pounding heart	27.3	18.2	36.4	0	18.2

Question: Please indicate how much you agree or disagree with each of the following statements.
Outcome measure: Internalised and systemic racism

	Strongly agree	Agree	Neither disagree/ agree	Disagree	Strongly disagree
I feel accepted by other Indigenous people	45.5	45.5	0	9.1	0
Indigenous people have less opportunities than other Australians	45.5	36.4	9.1	9.1	0
Indigenous people should try to think and act more like other Australians	0	0	9.1	36.4	54.6
I feel good about being an Indigenous person	54.6	45.5	0	0	0
Other Australians think that Indigenous people are better off because they get special treatment from the government	45.5	54.6	0	0	0
Other Australians think they are better than Indigenous people	27.3	45.5	27.3	0	0
There is hardly ever anything good about Indigenous people in the media (TV, radio, newspapers, etc)	27.3	27.3	9.1	27.3	9.1

Question: How often do you think about being Indigenous
Outcome measure: Race-consciousness

	Never	Once a year	Once a month	Once a day	Once an hour	Constantly
How often do you think about being Indigenous	0	0	18.2	45.5	0	36.4

(Table 3 continues on next page)

Question: Do the people that you mix with know that you are Indigenous Outcome measure: Ethnoracial identity within their social group						
	Hardly anybody	Not many people	Some people	Most people	Everyone	Unsure
Do the people that you mix with know that you are Indigenous	0	9.1	18.2	27.3	45.5	0
Question: Do people you meet for the first time know that you are Indigenous Outcome measure: Salience of respondents ethnoracial identity among strangers						
	Hardly anybody	Not many people	Some people	Most people	Everyone	Unsure
Do people you meet for the first time know that you are Indigenous	27.3	27.3	27.3	18.2	0	0

Table 3: Measure of Indigenous Racism Experiences (MIRE) survey results compiled (response rates presented as percentages)

forcing them to change their stereotypes and the way they act (P3, female, GPT1, rural, full time).

Further, cultural identity was seen to shape professional identity and career goals, with all participants cognisant of the health inequities that Indigenous peoples face and a desire to work in Indigenous health, which relates to the MIRE questionnaire constructs of race consciousness and salience of ethnoracial identity among strangers.

Over the years I thought you know would I work in clinical practice in that area... I would really like to... move into more... public health aspect of Aboriginal health. Because I just feel that is where you can make a difference (P1, female, recent Fellow, metropolitan, part time).

I grew up having pretty strong you know social conscience with... my Aboriginality and the wrongs that have happened to Aboriginal people, ...[a] pretty strong feeling about who I am and... what my morals and values come out of and that has basically shaped me, going towards... improving... the social determinants of health and... outcomes for Aboriginal people (P2, male, GPT1, rural, full time).

Training challenges: workplace cultural safety and racism

Online questionnaire participants reported low levels of being treated unfairly in the workplace. However, when asked about being treated unfairly at school, university or other education institution, three reported low levels compared with six reporting sometimes and two reporting often or very often being treated unfairly. This was comparable with six participants being treated unfairly in health settings by doctors, nurses or other staff at hospitals or doctors' surgeries. The online questionnaire did not specify in which workplace unfair treatment was occurring; however, these experiences of interpersonal racism were further explored in the interviews.

Cultural safety

Workplace and education cultural safety was discussed by interview participants as an important issue across medical school and training years. This theme relates to the MIRE questionnaire constructs of interpersonal racism, internalised and systemic racism and ethnoracial identity.

I remember feeling like I'm the only person in this room that this, like I feel like this really affects me, and nobody knows that this affects me... I remember feeling really uncomfortable, and I think that was the first time [talking about learning environments in medical school] (P1, female, recent Fellow, metropolitan, part time).

I have been really lucky that senior doctors or senior nurses have provided a culturally safe place for me,

where I have been upset or people said stuff to me, ...[that] bystander approach... for me it's been really helpful in my career... I don't think that can be underestimated (P2, male, GPT1, rural, full time).

White privilege and racism, that's kind of ingrained in that sort of working environment, ...they wouldn't think to do anything different, that it is always the Indigenous person who has to make space, make room, make allowances (P3, female, GPT1, rural, full time).

Racism

Experiences of racism for interview participants were varied, with some reporting minimal frequency of encounters and others feeling like it was pervasive across their workplace and training years, with both personal experiences and racism directed towards Indigenous peoples having an impact. This theme related to all racialised experience constructs explored in the MIRE questionnaire.

...when you're not considered to look like a stereotypical Aboriginal person, then that does reduce the amount of impact... and then you always get kind of shocked [responses] and their like 'but you don't look Aboriginal' and you're like what does an Aboriginal person look like? (P1, female, recent Fellow, metropolitan, part time).

I had people not only excluding me, but lying to me... there's a constant fear of am I doing my job right and am I doing right by my patients, ...and knowing that you were going to an environment where you didn't really fit in, but you weren't really welcomed either (P3, female, GPT1, rural, full time).

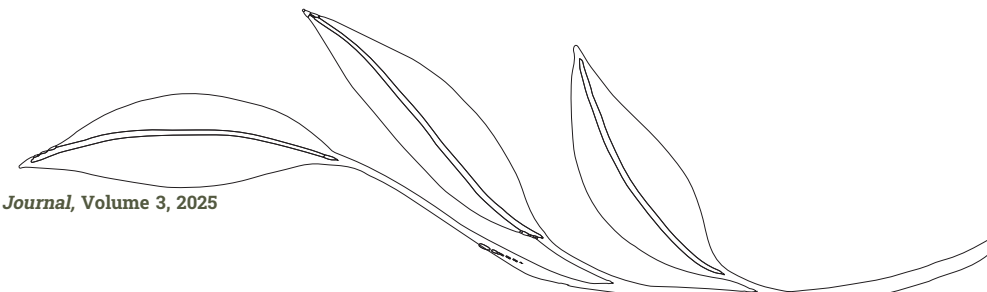
Additionally, racism directed from patients while working was a challenge to manage while maintaining professionalism. The MIRE questionnaire explored this through the items related to adaptive and maladaptive responses to racism, and interview participants expanded on this by describing the personal and professional approaches and responses in the workplace. When asked about their reactions to being treated unfairly, all online participants felt angry, while the majority reported feeling ashamed, trying to change self so it doesn't happen again, avoiding it in the future, and sometimes, often or very often ignoring, forgetting about it and accepting it as a part of life. Further interview questions surrounding interpersonal experiences of adaptive and maladaptive responses to racism in the workplace served to explore how interviewees operated during medical and GP training. The responses to racialised experiences were highlighted by interview participants who described the conflict between balancing their role as a health provider and being a target of racism.

I want to make it very clear that I am not engaging in that conversation, but also is it my place to really tell this person... that's quite a racist comment... but you're in a difficult space because... you're trying to build trust with that patient as well (P1, female, recent Fellow, metropolitan, part time).

I think the hard thing is like how do you go, where's the line between sort of, that's not appropriate and this needs to happen but also building some sort of therapeutic relationship (P3, female, GPT1, rural, full time).

Training facilitators: specific support, placements and mentorship/networking

Interview participants spoke about training facilitators within the three sub-themes of provision of specific support, culturally safe placements, mentorship and networking. This theme related to the MIRE questionnaire constructs of internalised and systemic racism, race consciousness and ethnoracial identity. The experiences explored in the interviews expanded on these concepts and highlighted the culturally and identity specific opinions surrounding improvements in medical training for Indigenous medical professionals.



Specific support

All interview participants spoke about specific support that they had accessed or desired throughout their training, including specific professional or organisational support people and structured training pathways.

> *I think if were really truly talking about supporting Indigenous doctors then that's one of the key things is [the College] keeping in contact with them post fellowship and talking about opportunities and giving them the encouragement and direction to get to where they want to go* (P1, female, recent Fellow, metropolitan, part time).

Placements

The importance of accessing Aboriginal community controlled organisations for placements during training was seen as aligning with their professional goals and as a culturally safe workplace. This aligns with the MIRE questionnaire construct of ethnoracial identity within their social group because on the measure asking about whether participants felt accepted by other Indigenous peoples, five participants agreed or strongly agreed, respectively. A sense of safety and acceptance within culturally concordant clinical placements was seen as important in training.

> *When I called them doing my preferences early on in training, I specifically asked to go to an AMS* (P1, female, recent Fellow, metropolitan, part time).
>
> *I was disappointed I wasn't able to work in an Aboriginal medical service in my first year in GPT1 or GPT2, that was a frustration for me* (P2, male, GPT1, rural, full time).

Mentorship and networking

Exploring further how GP registrars responded to racism in the medical workforce setting, interviewees expanded on the MIRE responses, which revealed that talking to others, like family or friends, was seen as beneficial by the majority, who reported sometimes, often or very often, using it to deal with being treated unfairly. Interview participants reported mentorship and networking with other Indigenous doctors as important sources of support throughout training and beyond. Networking with other Indigenous clinicians was also a key component.

> *...overall it's been... a positive thing for me as far as... getting access to mentors and... other Indigenous doctors or... going to conferences... where I probably wouldn't have, I wouldn't have bothered to go to a normal conference* (P2, male, GPT1, rural, full time).
>
> *I think what helped with that was... meeting other Aboriginal doctors, who had experiences similar to me, and I realised... even if I don't look black I can still have views and opinions and I was unsure if I was allowed to have that before* (P1, female, recent Fellow, metropolitan, part time).

Having a specific or dedicated mentor to provide more personal or career advice was equally important, which additionally aligns with the MIRE construct of ethnoracial identity.

> *...meeting other Aboriginal registrars and meeting the people that are mentoring and supporting you, as opposed to sort of emails about how you've gone, so I think that... would be number 1* (P2, male, GPT1, rural, full time).
>
> *I think the main things are always having a support person, someone who can speak up on the behalf of Indigenous GP registrars, who can do things without identifying the Indigenous doctors but also having a safe person that you can debrief to, either in your organisation, whether it be your GP trainer or the GP practice that you're working in* (P3, female, GPT1, rural, full time).

Discussion

Overall, Australian Indigenous GP trainees had racialised training, and workplace experiences and issues of cultural safety were identified. Three key themes that influence the training experiences of Indigenous GP trainees emerged from this study, which utilised an integrative mixed methods approach combining the MIRE questionnaire and semi-structured interview data: i) cultural identity, with the subthemes of professional wellbeing and professional goals and identity; ii) training challenges, including racism and career development; and iii) training facilitators, including specific support and mentorship. A summary of the findings from a combination of the MIRE questionnaire responses and interview data is presented in Box 1.

Cultural identity and professional wellbeing exploration showed the importance of Indigenous identity in the formation of professional goals and contributing to professional wellbeing and approaches to patient care. Taylor et al. (2019) previously reported cultural identity as a motivator for health students who want to positively contribute to Indigenous health and be a role model; the current findings support this. Similarly, previous studies have shown that African–American physicians have strong ties to their social identity, which influences their professional identities (Wyatt 2021). Thus, Australian Indigenous identity shapes professional goals for GP trainees, including the desire to positively contribute to Indigenous health outcomes as a GP.

There were challenges for participants in GP training, including a lack of cultural safety in some workplaces, and they felt the impacts of racism from both staff and patients. This was evident in the MIRE questionnaire responses regarding unfair treatment across various social settings, including educational and medical settings, and explored in more detail in the interviews with issues of cultural safety discussed by participants in educational settings, including postgraduate training and workplace settings. There is considerable literature (AIDA 2017; Garvey et al. 2009; Huria et al. 2014; Kairuz et al. 2021; Larson et al. 2007) outlining the effect of racism on Indigenous peoples, medical students and health professionals, with data confirming that these also exist for Indigenous Australian GP trainees. Laverty

Box 1. Summary of findings relating to barriers and facilitators for wellbeing of GP trainees' training, career and professionally

Barriers	Facilitators
Racism experienced in training and workplace environments Racism experienced in external settings Lack of cultural safety and anti-racism support from supervisors Lack of peer support	Nurtured and secure cultural identity Professional goals surrounding social justice and advocacy Specific training support for Indigenous trainees Culturally safe training placements and workplaces Mentorship and peer networks

Recommendations for training organisations

- Addressing racism and issues of cultural safety throughout training and beyond including through curriculum, supervision and training placements
- Providing opportunities to engage in mentorship and peer support with Indigenous trainee networks
- Dedicated policy and strategies surrounding training and professional wellbeing of Indigenous GP trainees
- Supporting opportunities to realise professional goals related to cultural identity for example opportunities for placement in Aboriginal Community Controlled Health Organisation settings.

and colleagues (2017) argued that cultural safety involves the specific embedding of Indigenous-led models of care into healthcare standards to increase clinician education and improve professional and patient experiences in relation to impacts of race. In addition, there is increasing pressure for accreditation and professional regulation standards to address and acknowledge systemic and institutionalised racism within the health system (Milligan et al. 2021).

This study's participants reported various adaptive and maladaptive ways in which they deal with racism with avoidance and feelings of anger or frustration, the most reported strategies in the MIRE questionnaire responses. The interviewees also discussed strategies for dealing with direct and indirect racism such as avoidance, but also expanded on coping strategies such as peer support, especially with Indigenous doctor networks and support. Furthermore, the interviews highlighted variations in exposure to direct interpersonal racism, also the difficulties with racism directed towards Indigenous peoples or the institutionalised racism that was identified in workplaces. These findings are consistent with previous reports, which have shown that Indigenous medical students have felt pressured to teach others about Indigenous cultural issues, address confronting attitudes towards Indigenous peoples and further experience discrimination and feelings of inadequacy in comparison with other students (AIDA 2005; Taylor et al. 2019), demonstrating a lack of cultural safety in medical education that may serve as a barrier to course completion. Vass and Adams (2021) propose that GP education lacks curriculum focus and teaching quality surrounding content pertaining to racism, which may indirectly perpetuate systemic racism. The current findings are congruent in highlighting the importance of cultural safety and systemic factors impacting Indigenous GP training. Furthermore, discrimination directed from patients contributes to issues of cultural safety and this was seen within the current study, with a conflict arising within the doctors and their caring role. Paul-Emile et al. (2016) reason that organisations, such as hospitals and healthcare services, need to establish acceptable conduct expected from patients, as well as appropriate responses, to protect their racial minority workforce and create safe working environments. Thus, the current findings support previous reports regarding cultural safety issues in workplace and educational settings.

A lack of culturally safe workplaces is recognised in Australia, with AIDA finding that half of their Indigenous doctor survey respondents felt culturally safe in their workplace; they have therefore proposed mandatory cultural training along with clearer complaints and follow-up procedures regarding racial discrimination as ways to address this (AIDA 2017). Culturally safe healthcare that incorporates the protective elements of culture for a holistic approach to health and wellbeing is thought to be essential in patient care and in creating learning environments for trainee doctors that are respectful and overcome power imbalances (Kimpton 2014). The current study emphasises the importance of culturally safe workplaces and training programs that respect and acknowledge the importance of Aboriginal identity alongside the specific challenges faced, such as racism, which is pervasive across the medical careers of Indigenous doctors.

The interview data also highlighted training facilitators, which included the provision of specific support, specific and culturally safe placements, mentorship and networking. Interviewees identified facilitators that were congruent with a previous study that highlighted factors to support Aboriginal and Torres

Strait Islander health-related degree students by including networks, role models, cultural and academic support, and financial assistance (Taylor et al. 2019). Furthermore, proposed strategies for Indigenous specialist college trainees include economic assistance, cultural support in the form of mentors and networks, and political support in the form of representative committees and organisational structures that support trainees and cultural safety (Saunders 2024). Deroy and Schütze (2019) indicated in their study that retention of Aboriginal staff in Aboriginal health services may be aided by support from peers, including opportunities for debriefing, reflection and recognition of workload. Accessing mentors and role-models can be difficult because whilst there is diversity amongst UK medical student cohorts, there is a lack of diversity with medical educators (Kmietowicz 2020), potentially providing fewer opportunities. However, Garran (2019) argues that it is not the sole responsibility of minority physicians to address race issues – organisational approaches are also required. Workplaces have a responsibility to integrate and engage with cultural safety and support the engagement of Indigenous peoples with professional organisations that provide networking, culturally safe career advice and advocacy (Bretherton 2014). The AIDA reports that workplaces feel most culturally safe when they have a majority Indigenous workforce, staff experienced in working with Indigenous peoples and mandatory internal programs on Indigenous health issues (AIDA 2017). The current study supports these findings, with participants wanting more specific support, mentorship and networking above what is currently being provided.

Participants in this study outlined the desire for culturally safe specific placements, as well as provision of support networks that recognise their Aboriginal identity and assist their career progression. Strategies to help retain Indigenous medical students may be more broadly applied to Indigenous trainee doctors and include access to financial assistance, provision of Indigenous role models, inclusion and embedding of an Indigenous health curriculum, and appropriate recruitment and selection processes (AIDA 2005; National Aboriginal and Torres Strait Islander Health Council 2008; Garvey et al. 2009; Taylor et al. 2019). In America, medical students from racial minority groups found mentorship and role-modelling, scholarships, racially concordant support networks, community connectedness, and the ability to relate to and comfort other racial minority patients to be facilitators of their academic success (Johansson et al. 2011; Liebschutz 2006; Odom 2007). Mentorship and networking were important facilitators in GP training for participants in this study; however, previous studies focusing on medical students have not captured the important aspect of culturally safe training placements, which was revealed in this study.

Strengths and limitations

This study included the use of the mixed methods model to provide an integrated approach to analyse the experiences of Indigenous GP trainees, along with the use of a validated measure looking at lifetime exposure to racism. The study used the MIRE questionnaire to explore aspects of lifetime exposure to racism, which has been shown to have a high prevalence (Paradies 2006a), and more recent and setting-specific experiences with semi-structured interviews, which reduce the effects of recall bias and enable a deeper understanding of the experiences in the specific timeframe from medical school through to GP training. Items in the MIRE survey, such as experiences of racism in workplace settings, lacked specificity in relation to the healthcare workplace and the interviews were able to explore these experiences

in more detail. While there are difficulties measuring perceived racial discrimination, Paradies argued that instruments with a greater number of items and those which leave the timeframe of racialised experiences underdetermined or for <1 year show stronger associations regarding impact of racism on health outcomes (Paradies 2006b; Paradies 2008), justifying the use of the MIRE in the current study. The authors acknowledge that this study specifically sought responses regarding experiences with racism and this increased potential confirmation bias. Future research should consider exploring general experiences during GP training, as there may be an array of experiences and phenomena not captured by the approach in this study, given the paucity of information in this area.

The inability to perform interviews face to face, which may be more aligned with Indigenous ways of knowing and doing, and the low participant number were limitations of this study. The low uptake may reflect the sensitive nature of the topic and advertising through email mailing list networks, which limited generalisations made from the quantitative questionnaire data; however, the small sample size was potentially offset using mixed methodology and in-depth interview data. The authors acknowledge that those trainees who opted in to complete an interview may have experienced higher levels of racism and the survey may have primed their interview responses, introducing a source of bias. In addition, the MIRE is intended for use with patient cohorts and to be delivered face to face; therefore, use in this context may have limited its validity. The small sample size is a significant limitation and generally limited the generalisability of the findings. Further research should explore experiences of GP training programs with larger numbers of Indigenous GP trainee representatives, along with expanded focus on strategies that have the greatest benefit for trainees.

Conclusion

Indigenous GP trainees in Australia value their cultural identity in relation to their professional goals and wellbeing. However, challenges for trainees centre around the lack of cultural safety and the presence of racism, which is pervasive across their professional life. Strategies to address this within specialist medical education and training could include further provision of specific support, culturally safe training placements, networking and mentorship. Essentially addressing issues of cultural safety and racism through systemic change within each section of healthcare and medical education, training and healthcare delivery serves to build a health system that is culturally safe for practitioners and patients alike. Future research should focus on clarifying best practice supervision, training and assessment, and how general practices can implement cultural safety for patients and trainees.

Author contributions

This project was led by Talila Milroy under the supervision of Jacqueline Frayne. All authors made significant contributions to the entire research project, including development, data collection, data analysis and manuscript writing. All authors approved the final manuscript prior to submission for publication. T. Milroy and J. Frayne: Conceptualisation, methodology, validation, formal analysis, resources, data curation, writing – review and editing, visualisation, funding acquisition. T. Milroy: Investigation, writing – original draft, project administration. J. Frayne: Supervision.

Data sharing

The project was developed with Aboriginal and Torres Strait Islander ethical principles at the forefront. The raw

data include transcripts from participants and responses to an online survey, which explore the sensitive topic of racism. Therefore, raw data were not made available to protect the interests and privacy of participants.

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Author biography

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Supplementary material

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