Exploring cultural safety and person- and patient-centred care in general practice: Voices of Aboriginal and Torres Strait Islander peoples

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Abstract

Background: Aboriginal and Torres Strait Islander peoples in Australia continue to experience significant health disparities rooted in the ongoing impacts of colonisation, systemic racism, and cultural disconnection. While patient-centred care (PCC) is widely promoted as a gold standard for high quality and respectful healthcare, its application to meet the unique needs of Aboriginal and Torres Strait Islander patients in general practice remains poorly understood. Instead, cultural safety has been offered as a contextually grounded approach to care, one that critically examines power imbalances, cultural identity, and the historical forces shaping healthcare experiences.

Objective: To examine the alignment between Aboriginal and Torres Strait Islander peoples' perspectives on interacting with general practitioners (GPs) and the principles of PCC and culturally safe care.

Methods: A mixed method-approach was employed, beginning with a survey and followed by qualitative interviews that underwent thematic analysis. Aboriginal and Torres Strait Islander adults with experiences of general practice care were invited to participate.

Results: Seventy Aboriginal and Torres Strait Islander people participated. Findings highlight the centrality of a trusting and caring relationships, effective communication, respect for diverse Indigenous identities, individualised care, clinical competence and the GP's attitude. Key enablers of culturally safe care included adequate time, continuity of care, genuine engagement, informed consent, confidentiality, privacy, and a physically welcoming environment.

Conclusion: Our study found significant diversity in participant perspectives, reinforcing that a 'one-size fits all' approach is inappropriate. The principles of PCC support culturally safe care through adaptability and respect for patient values.

Keywords

Patient-centred care, cultural safety, Aboriginal and Torres Strait Islander health, Australia, Indigenous healthcare, equity, healthcare delivery

Background

Culturally safe healthcare is increasingly recognized as a critical component of high-quality, equitable care (1), particularly in populations shaped by colonisation and systemic marginalisation. Originating in Aotearoa New Zealand through the work of Ramsden (2), the concept of cultural safety emphasizes the patient’s experience of care, acknowledging that safety is defined not by providers but by those receiving care (2). It demands not only interpersonal respect and empathy but also recognition of historical injustices, systemic power imbalances, and the ongoing impact of racism and colonization in healthcare settings (2, 3).

Cultural safety has been advanced internationally in work with other Indigenous populations, including First Nations peoples in Canada, the United States and Australia. Across these settings, scholarship similarly identifies racism, colonisation, and structural inequities within health systems as key drivers of health disparities, while emphasising Indigenous self-determination, relational care, and respect for cultural identity as central to equitable healthcare delivery (28–31).

In Australia, a recent scoping review highlighted that Aboriginal and Torres Strait Islander patients continue to report high levels of discrimination, exclusion, and cultural disrespect in healthcare settings (4, 5). Such experiences contribute to delayed or avoided care, poorer health outcomes, and persistent disparities in chronic disease management, mental health, and life expectancy (4, 6). This occurs despite commitments in national policy frameworks, such as the National Aboriginal and Torres Strait Islander Health Plan (1), to embed culturally safe care in health systems.

The Australian Health Practitioner Regulation Agency (Ahpra) defines cultural safety as:

> "*Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities*. *Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism*" (3).

This definition also emphasizes that cultural safety is not defined by healthcare providers or institutions but by the patients themselves, acknowledging their unique cultural identities and experiences (3).

To practice cultural safety, health practitioners are expected to (3):

- Acknowledge colonisation and systemic racism and understand how these factors impact individual and community health.
- Address personal biases, assumptions, stereotypes, and prejudices, ensuring care is holistic, free of bias, and racism.
- Recognise the importance of self-determined decision-making, fostering partnership and collaboration in healthcare driven by the individual, family, and community.
- Foster a safe working environment, demonstrating leadership that supports the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.

The ability to meaningfully assess whether health practitioners achieve these expectations in a general practice consultation—as defined by the recipients of care—is not only a matter of quality improvement but a critical element of health equity and human rights. However, health and education systems currently lack validated tools for assessing whether cultural safety has been achieved in individual consultations (7).

Cultural safety is often taught and assessed as a distinct skill set (8-10). However, the tenets of culturally safe care overlap significantly with contemporary patient centred care concepts (11), which have established metrics of assessment (12). While tools exist to explicitly assess the delivery of PCC in general practice (7), few integrate the specific indicators of cultural safety such as recognition of cultural identity, acknowledgement of past trauma, and trust built through long-term relationships and community engagement (12).

While there is no universal agreement on a definition of PCC (13), common themes emphasise collaborative care, respectful relationships between patients and clinicians, empathy, shared decision-making, and the provision of individualised care that respects patients' needs, values, and preferences (13-18)—"*Nothing about me without me*" (19). While the terms patient-centred and person-centred care are often used interchangeably, person-centred care is increasingly seen as a broader notion––one that shifts the focus from managing illness to supporting individuals in the context of their life circumstances, culture, goals and relationships (16).

Both PCC and person-centred care have been conceptualised through various models, each emphasizing different dimensions of care. For example, a 2018 review of reviews by Eklund (16) examined the conceptual distinctions between the two, identifying shared elements such as empathy, respect, engagement, relationship, communication, shared decision-making, holistic and individualized focus, and co-ordinated care. The primary point of divergence lay in the overarching goals: patient centred care often emphasises functional outcomes and clinical management, while person-centred care aspires to support a meaningful life as defined by the individual. Scholl et al (17), as cited in Eklund's review, described an alternative model for PCC with four core principles: the essential characteristics of the clinician, clinician-patient relationship, recognition of the patient as a unique person, and the application of a biopsychosocial perspective. Brickley et al (14) propose another model of PCC based on four key themes: understanding the whole person, finding common ground, experiencing time, and aiming for positive outcomes. This model was subsequently validated by Australian GPs and patients, reinforcing its relevance to local general practice settings (15).

While often framed as a universal approach to improving healthcare quality, the principles of person-centred care align closely with the longstanding practices of Aboriginal Community Controlled Health Organisations (ACCHOs) (20, 21). Established in the early 1970s, ACCHOs pioneered a model of care that extends beyond the clinic to advocate for systemic equity, cultural sovereignty, and person-centred care (20, 21). It centres on self-determination, holistic health, and culturally safe engagement. This approach provides accessible, relationship-based care that addresses not only clinical needs but also the social, cultural, historical, and economic determinants of health (21). This comprehensive model is evidence-based, tailored to the specific needs of Aboriginal and Torres Strait Islander people, and has been associated with improved patient engagement, continuity of care, and health outcomes (21). ACCHOs have long been recognised as a leading example of person-centred, culturally safe primary health care (20). In many ways, the emergence of patient and person-centred care in mainstream health reflects a delayed adoption of these foundational Indigenous-led concepts.

While person-centered or PCC frameworks tend to shape policy and clinical guidelines across Australian general practice (18), they have often been developed within Eurocentric healthcare paradigms (18). Indigenous scholars and practitioners have developed additional models that reflect the specific cultural, historical, and social realities of Aboriginal and Torres Strait Islander peoples. McKivett et al.’s (11) concept of "healing conversations" and Pitama et al.’s Meihana Model (22) provide culturally responsive theoretical frameworks for PCC in general practice, emphasising relational trust, cultural identity, and holistic engagement with Māori and Aboriginal and Torres Strait Islander patients through acknowledgment of broader social and historical contexts.

However, despite the success of the ACCHO model of care (23) and widespread adoption of PCC in general practice (24), there is limited evidence exploring how patients experience cultural safety within this patient-centred ACCHO framework. While clinician-facing cultural competence frameworks exist (12), they often emphasize knowledge and skills over the patient’s subjective experience of safety. Standard PCC tools (e.g., outcome or patient-reported experience or measures, PREMs) often fall short in evaluating experiences that are central to Aboriginal and Torres Strait Islander health (25-27). They typically do not fully capture the relational, cultural, and historical dimensions of care that are central to the ACCHO model of care (25). Nor do they assess whether a patient experienced racism, felt their cultural identity was respected, or whether structural barriers to care were acknowledged or addressed (25). Furthermore, few studies have examined how patients themselves define what makes a consultation feel “safe,” “respectful,” or “good,” and how those definitions intersect with established models of PCC.

This study aims to address that gap by exploring whether patient or person-centred care models, which are widely used in both ACCHOs and other general practices, can be used or adapted to contribute to an assessment of cultural safety in GP consultations with Aboriginal and Torres Strait Islander patients. By analysing patient narratives, we aim to examine how these experiences align with, challenge, or extend existing models of PCC. By centring the voices of Aboriginal and Torres Strait Islander patients, this research aims to inform the development of care models and assessment tools that reflect Indigenous-defined safety and respect, rather than relying on provider-driven interpretations of “good” care.

3. Methods

Research design

This manuscript draws on data from a broader qualitative study investigating how Aboriginal and Torres Strait Islander people experience and assess cultural safety within general practice consultations. The same dataset was also used in a separate, as-yet-unpublished analysis examining the alignment of participant perspectives with clinical yarning.

The research design and methodology for the broader project have been previously described in detail (7). However, relevant aspects are summarised here to provide context for this phase of the study. The research was developed and conducted in partnership with an Aboriginal Community advisory group, which guided the project direction, ensured cultural relevance, and supported data interpretation throughout. The group has guided this project for the past seven years, with membership evolving as individuals moved in and out due to changing life circumstances, such as changing work, family responsibilities, health, and capacity. Its members have included Aboriginal Health Workers and Practitioners; senior managers serving as cultural educators, mentors, and peak consumer representatives; youth workers; aged care facilitators; and child safety workers; who collectively reflect a broad range of professional and community perspectives. Ethics approval was granted by the James Cook University Human Research Ethics Committee (H8296).

Setting and participants

This phase of the study involved participants recruited from three Aboriginal Community Controlled Health Services (ACCHSs) and one mainstream general practice in Queensland, Australia. One regionally located ACCHS was actively involved from the study’s inception, with staff from this service comprising the advisory panel. Senior representatives from this service, including Author1 (a GP), and Author4 (the board chair), invited two additional ACCHSs situated over 750 kilometres apart. These organisations included both regional and very remote communities with which the service maintained strong professional and community connections. Collectively, the participating services provide care to Aboriginal people from over 15 different nations, reflecting the cultural and linguistic diversity across Australia's more than 250 Aboriginal nations (28).

Participant recruitment occurred through verbal invitations extended by clinic staff at participating services. Where workload allowed, staff invited all patients attending during the recruitment period. For the non-ACCHS site, recruitment was conducted via email. Snowball sampling was used to supplement recruitment and included participants who attended other mainstream general practices. Participants were offered the choice of face-to-face or virtual interviews, individually or with a support person. At ACCHSs, interviews were often scheduled to coincide with participants’ medical appointments. The interviewer (HW) was embedded at each participating service during data collection to build trust and support relational engagement with participants. Participants were provided with gift vouchers to acknowledge their contribution.

Eligible participants were Aboriginal and/or Torres Strait Islander people aged 18 years or older who were able to provide informed consent.

Data collection

Before the interview, participants completed a brief demographic survey via Qualtrics, either independently or with assistance from HW, depending on participant preference. The survey was followed by a semi-structured interview that explored key components of cultural safety, as defined by Ahpra (3), to understand participants' perspectives on what constitutes a culturally safe general practice consultation. A previously published interview guide was used (7).

Following the interview, participants were asked to rate the importance of selected culturally relevant elements—such as eye contact, use of silence, inclusion of traditional language or spirituality, and the presence of family or Elders (29)—using a five-point Likert scale. All participants provided written informed consent.

Data analysis

Quantitative survey data were analysed descriptively to contextualise the sample and inform interpretation of qualitative findings. Interview transcripts were analysed using Braun and Clarke's thematic analysis approach (30). Initial deductive coding of all transcripts was undertaken by Author1 and guided by the Ahpra definition of cultural safety (3), applying predefined domains including critical reflection, knowledge, attitudes and skills, practitioner behaviours, and the absence of racism. Emergent, inductive codes were added as new themes developed. HW reviewed a sub-set of codes and themes, with interpretation further refined through ongoing team discussions, input from the advisory group, and insights gained through conference presentations to strengthen rigour and address bias. A secondary analysis involved mapping the coded data to core domains of PCC to examine intersections between culturally safe and PCC approaches.

Patient and public involvement

Aboriginal and Torres Strait Islander community members were actively involved throughout the study. The research reflects priorities identified by the Aboriginal health workers and other staff at the ACCHS (where Author1 and Author4 are based), who reported challenges in providing formative feedback and assessment to learners in the absence of defined benchmark or framework for culturally safe care (31-33). The community advisory group contributed to the development of research questions, advised on recruitment strategies, and played a central role in interpreting data by reviewing emerging themes and participant quotations. The research centres the voices and perspectives of Aboriginal and Torres Strait Islander people.

Reflexivity

The research team brought diverse professional and cultural perspectives to this study. Author1 is a PhD candidate and GP working in Aboriginal health, who reflects critically on her own uncertain cultural heritage and positioning within this work. Author2 is a public health researcher with expertise in health systems and equity. Author3 is a GP and academic with experience in primary care research and education. Author4 is an Aboriginal nurse, and Indigenous knowledge broker, bringing lived experience and community-informed expertise. Throughout the study, we engaged in ongoing reflexive dialogue regarding our positionality, professional roles, and assumptions, and how these may shape data collection, interpretation, and representation of participants' voices.

4. Results / Findings

Seventy Aboriginal and Torres Strait Islander individuals participated in this phase of the study. Although our initial target was a sample size of 40 participants (10 from each ACCHS and 10 from non-ACCHS practices), snowball recruitment at one site led to a higher number of participants. In consultation with the research team and the advisory group, we decided to continue collecting data to ensure that all willing participants’ voices were fully represented. Two additional participants were interviewed; however, both disclosed during their interviews that they were non-Indigenous. As their data did not meet the inclusion criteria, it was excluded from the analysis. Participant demographics are presented in Table 1.

Table 1: Participant characteristics

		Total	**Site A** **N=33**	**Site B** **N=12**	**Site C** **N=12**	**Site D** **N=13**
Indigenous population %		NA	11.5%	4.8%	NA	6.2%
Location classification		NA	Very remote community	Regional centre	NA	Large rural town
Age	8-34	26 (37%)	9 (27%)	4 (33%)	6 (50%)	7 (54%)
	35-54	21 (30%)	7 (21%)	7 (58%)	2 (17%)	5 (39%)
	55+	23 (33%)	17 (52%)	1 (8%)	4 (33%)	1 (8%)
Gender	Male	17 (24%)	8 (24%)	5 (42%)	2 (17%)	2 (15%)
	Female	53 (76%)	25 (76%)	7 (58%)	10 (83%)	11 (85%)
Education	Year 9 or below	12 (17%)	10 (30%)	0 (0%)	1 (8%)	1 (8%)

	Year 10 -12	31 (44%)	14 (42%)	4 (33%)	5 (42%)	8 (61%)
	Certificate III, IV or diploma	19 (28%)	8 (23%)	7 (59%)	1 (8%)	3 (23%)
	Bachelor and above	8 (11%)	1 (3%)	1 (8%)	5 (42%)	1 (8%)
Employment	Employed	34 (49%)	10 (30%)	8 (67%)	11 (92%)	5 (38%)
	Unemployed	25 (36%)	13 (39%)	4 (33%)	0 (0%)	8 (62%)
	Retired	11 (16%)	10 (30%)	0 (0%)	1 (8%)	0 (0%)
Income	Low	50 (72%)	27(82%)	6 (50%)	5 (42%)	12 (92%)
	Medium	19 (27%)	1 (18%)	6 (50%)	6 (50%)	1 (8%)
	Not stated	1 (1%)	0 (0%)	0 (0%)	1 (8%)	0 (0%)

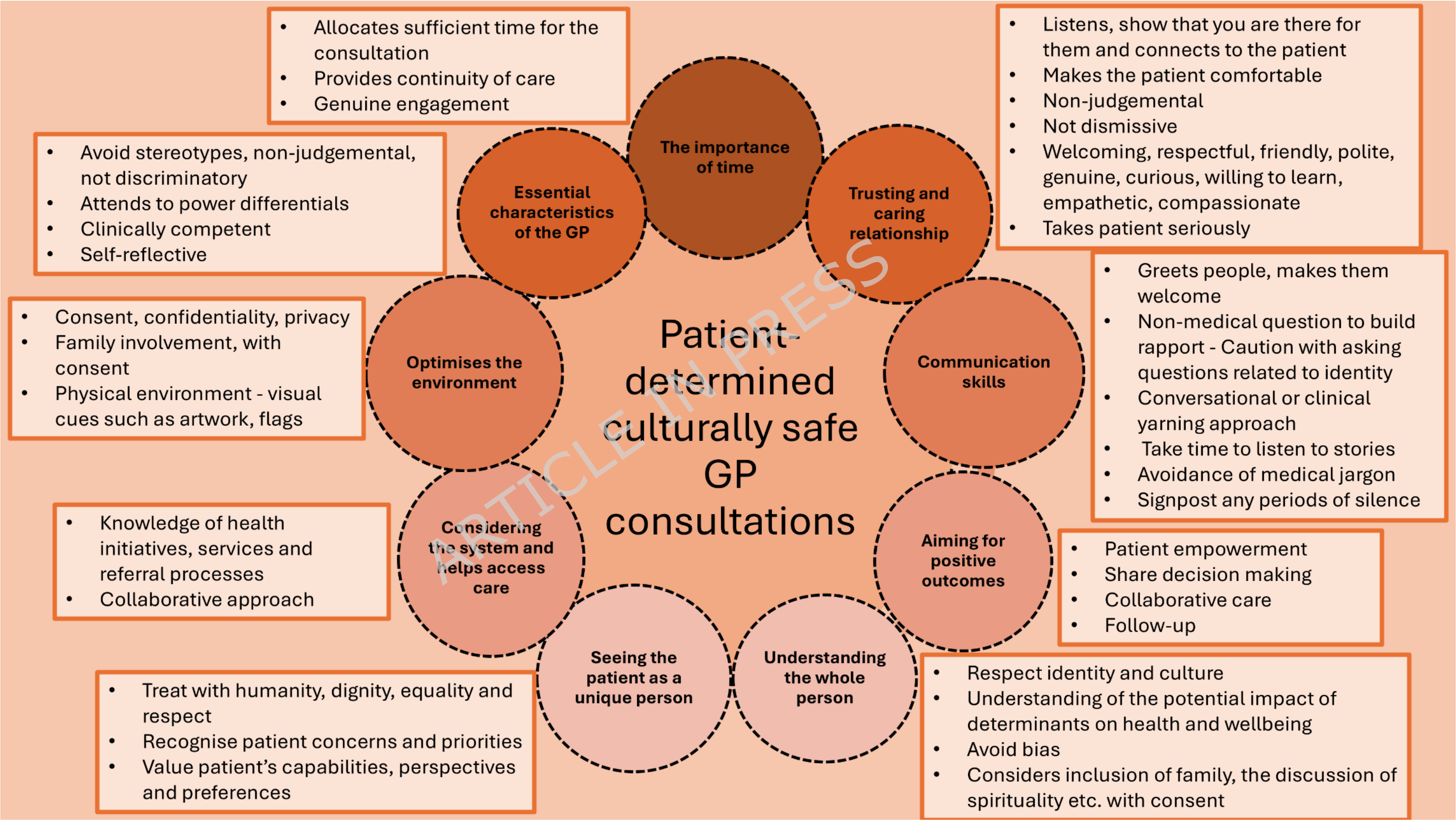
Data collection involved a combination of individual and group interviews, with the latter consisting of 2–3 participants. Over 29 hours of interview data were recorded. Interview durations ranged from 7 to 66 minutes, with an average length of 27 minutes.

To enhance readability, we edited the quotes to align them with written text rather than conversational speech. Consequently, we removed many conversational fillers such as "you know," "I guess," "like," "yeah," as well as redundant phrases. A member checking process was conducted, but only two participants responded to the request. These participants reviewed their own quotes and assessed a selection of other quotes to ensure the integrity and accuracy of the meaning. Notably, the findings often reflect conflicting participant priorities.

Participants have been identified by site (A-D). Sites A, B and D represent participants recruited from the three different ACCHs. Site C collectively represents different mainstream general practices. Participants have been sequentially numbered for anonymity. For example, Participant 3 at Site A is noted as Site-A:P3.

The results are presented by mapping participant perspectives to a key common theme from existing models of PCC. The Community advisory group selected the preferred wording for the theme. The themes and how they map to contemporary models and culturally safety definitions are presented in Appendix 1. Findings overlap between themes. A summary of the findings is represented in Figure 1 and may be a useful visual model.

Figure 1 - Summary of key findings:



- Allocates sufficient time for the consultation
- Provides continuity of care
- Genuine engagement

- Listens, show that you are there for them and connects to the patient
- Makes the patient comfortable
- Non-judgemental
- Not dismissive
- Welcoming, respectful, friendly, polite, genuine, curious, willing to learn, empathetic, compassionate
- Takes patient seriously

- Avoid stereotypes, non-judgemental, not discriminatory
- Attends to power differentials
- Clinically competent
- Self-reflective

- Greets people, makes them welcome
- Non-medical question to build rapport - Caution with asking questions related to identity
- Conversational or clinical yarning approach
- Take time to listen to stories
- Avoidance of medical jargon
- Signpost any periods of silence

- Consent, confidentiality, privacy
- Family involvement, with consent
- Physical environment - visual cues such as artwork, flags

- Knowledge of health initiatives, services and referral processes
- Collaborative approach

- Patient empowerment
- Share decision making
- Collaborative care
- Follow-up

- Treat with humanity, dignity, equality and respect
- Recognise patient concerns and priorities
- Value patient’s capabilities, perspectives and preferences

- Respect identity and culture
- Understanding of the potential impact of determinants on health and wellbeing
- Avoid bias
- Considers inclusion of family, the discussion of spirituality etc. with consent

1.Essential characteristics of the GP

Participants described four core characteristics of GPs: attitude, attention to power differentials, clinical competence, and self-reflection.

Attitude

Participants highlighted the importance of GPs avoiding stereotypes, being non-judgemental, and providing equitable care. Being treated without paternalism and regarded as equal to all other patients was seen as fundamental to a positive and safe experience.

> *Not putting us all in the box, “Oh, they're all alcoholics. Oh, you get trouble with the kidneys. How much do you drink? How often do you drink?”. Site-A:P6*

This quote reflects a broader concern that Aboriginal and Torres Strait Islander peoples are too often pre-judged based on racialized health stereotypes. For participants, being free from these assumptions, and instead treated with emotional intelligence—recognising concepts of shame, family dynamics, and the difficulty many people experience in accessing healthcare—
fostered a sense of safety.

> *You know that you're in a safe space…They're more aware of your culture and how Aboriginal families work together and against each other. They know that you might be going in there too shamed to be talking about something - so they will tread gently with you. Site-B:P7*

> *You don't feel judged from what you're coming to them with. For a lot of people getting to the doctors is hard enough for them. So then being judged by the one person that you should feel most comfortable to talk to them about it. Site-C:P7*

Participants valued GPs who were personable, respectful and genuinely interested in them.

> *The attitude of a good doctor is friendly. Takes time to actually understand and talk to you. Instead of just doing a diagnosis and whatever, it's actually about getting to know you as a patient and a person. And treating me with respect.* Site-A:P33

> *Just acknowledging that we are Indigenous and respecting that and our beliefs. We've got different beliefs, every person does, even if you are non-Indigenous. Respect their culture, identity, religion, all that type of stuff. We're all one people at the end of the day.* Site-B:P2

Respect encompassed qualities such as kindness, courtesy, active listening, and a willingness to acknowledge and engage with the person's identity, beliefs, and experiences. It was perceived through words and actions—tone of voice, body language, eye contact, and clear, inclusive communication:

> *It's your voice, your eye contact, body language. It's just being pleasant, just being open and honest. Just treating them with courtesy because you can get doctors that are quite rude. Well, obviously, they're not treating you with respect. And if they're being short and sharp, but also if they're using words that they know the patient might not even comprehend...Just be mindful of who you're dealing with and just treat that person like you would treat your own family, treating them how you would like to be treated - with respect and kindness. Culture is not always the most important thing. It's just the respect and courtesy as a person, as a human being...Have integrity, honour, and compassion when you're dealing with someone that wouldn't be there unless they have to.* Site-A:P31

Racism and clinical detachment were experienced as unsafe and harmful.

> *Just being treated as one…. not being racist—respect our culture as Aborigines as well. Site-A:P13*

> *I don't like doctors that are rude. I just like doctors that understand the situation. I don't like doctors that look at you funny when you go there—like you're not doing something properly. I like doctors that understand your situation—the whole reason that you're there.* Site-A:JointInterview3
> *They just came across really rude and, and I felt like it was like because of my Indigenous background.* Site-D:P4

Attention to power differential

Participants were acutely aware of patronising behaviours and hierarchical attitudes that undermined their sense of respect and safety. They described discomfort when practitioners "*think they're better than their patient*," (Site-D:P8) and emphasised the importance of GPs who "*bring themselves down to the level of the person*," (Site-D:P8) rather than adopting a "*high and mighty*" (Site-D:P8) stance that risks alienating patients. Others spoke of being looked down on: "*They look at you like you don't know nothing… and that makes you think we don't know nothing about our health*" (Site-A:JointInterview1). For many, safety was linked to being treated with dignity and equality: "*Doctor that listens, doctor that treats you as equal—not above you, not below you, just equal*" (Site-C:P3). As one participant summarised, it's about "*just talking to me like I'm a normal person and not the whole, 'I'm the doctor, you're the patient' type thing*" (Site-C:P6). One participant described:

> *Some doctors take that opportunity to put us down and dehumanise us and demoralise us. And it makes you feel like shit, and it makes you not want to come back to these places…Their gesture, their vibe shows off a*

> *lot— we can definitely feel and see it…When they're being rude and the way they're speaking to— they're trying to belittle us…And you don’t want to say something because…you don't want them to do anything to you. So, you just let them talk down to you and treat you like shit until it's just over and done with.* Site-A:JointInterview2

Participants identified means for GPs to minimise the power differential including adopting active listening and conversational or yarning approach to the consultation, relaxed body posture, and casual dress style.

> *Open body language. Not stuff that's like closed off or domineering or stuff like that. Just an open, relaxed presence. Good eye contact, good communication.* Site-D:P1

> *Be open to listen to what the person is saying without talking down to them and take on any take on board any cultural beliefs that person has.* Site-A:P21

Participants also responded positively to GPs who balanced professionalism and clinical expertise with humility and attentiveness:

> *You're like, this doctor's actually caring about me, but she's like sophisticated and knowledgeable and learned. And she knows all so many things. And she's a doctor. But she wants to know if she's interrupting my time…Whereas we're so dependent on them but she kind of flips it around that you're so important, become more important than her status…*Site-B:P7

Participants discussed the power differential that can be created when a GP has been privileged to learn more about Aboriginal and Torres Strait Islander history, language or culture than Aboriginal and Torres Strait Islander people.

> *I find it more intrusive, why has a doctor got that one's own language and you can have someone that's from this country and hasn't learnt the language…they could've been in foster care, might not know it, or they might have been brought up somewhere else. Site-B:P11*

Clinical competence

Clinical competence was seen as essential, encompassing safe prescribing, management of acute and chronic conditions, recognition of mental health needs, holistic care, and awareness of professional limits. Beyond technical skill, participants valued doctors who could clearly explain health issues in relatable terms, offer meaningful education, and engage them as partners in treatment planning and decision-making.

> *They don't need to know our history—as long as they respect us as Aboriginals and The First Nations people. I don't feel the need for them to know a lot of history as long as they know their medicine.* Site-A:P12

> *Just someone who understands why you're there to see him and are there any underlying issues like if you're stressed out or anything, you've got depression or whatever.* Site-A:P7

> *I get some doctors can't do everything. But we would like the GP to be at their best of their knowledge, and we'd like their best of care. Just because everyone deserves the best of care, everyone deserves a good doctor, for them to be treated properly by a doctor.* Site-A:JointInterview2

Participants also considered it important for GPs to have knowledge of health inequity and the epidemiology of disease in Aboriginal and Torres Strait Islander people *"Aboriginals are more prone to get sick than what the white people are".* Site-D:P9

> *It's just a matter of being Aboriginal and a lot of people don't really understand that, and I think that they think we neglect ourselves or we don't care about it. I think they need to accept that a lot of Aboriginal people lose a lot of family members and to all these chronic diseases and it's not always the lifestyle. So, I'm just saying, don't judge people.* Site-B:P10

However, participants expressed diverse opinions on the relevance of GPs' knowledge of Indigenous history, including awareness of colonization, the Stolen Generation and intergenerational trauma. Some participants felt this awareness was unnecessary in consultations and minimised potential historical impacts on their health: "*No, [colonization and history] it's not [important]. He's only got to know me".* Site-A:P32

> *Well, people need to know the history and to why people might be the way they are. Because there's a story to be told there as to why things are the way they are. So, have a look at the history - bunch of people were massacred, well why were they massacred? Innocent people sitting there with no weapons…That's very important for all to know. Site-C:P12*

> *I think that if that my GP knows Aboriginal culture then when you're talking about things that that have happened to in the past you feel like they're going to understand that because they're immersed in Aboriginal culture all the time. They're seeing the effects of different things that Aboriginal people are having or suffering—that transgenerational trauma and stuff like that. So, there's very deep, deep feelings and emotional, behavioural, and all of that type of stuff from those incidences. Site-B:P7*

Self-reflection

Although self-reflection was not directly prompted in the interviews, some participants called for GPs to engage in active, ongoing self-reflection as a critical aspect of care. This included recognising personal limitations, questioning dominant norms, and taking responsibility for their own learning. As one participant explained:

> *So, attitudes that don't promote colonialism, attitudes that really don't support the status quo, attitudes that challenge, attitudes that take a GP to be brave… So, we're moving from being in that safe spot to being brave…and being able to quickly reflect on your practice…And reflecting on attitudes as well.* Site-D:P2

Others highlighted the need for GPs to take initiative in their cultural learning, rather than relying on Aboriginal and Torres Strait Islander people to provide that education:

> *It's not like our job to teach you [doctors] —educate yourselves before going into a field that you're unaware of… And not just your annual work stuff— cultural excursion where you go to a museum…Site-A:JointInterview2*

Another participant spoke positively of a GP who modelled this reflective approach:

> *She recognises that there may be areas that she doesn't know a lot about but is willing to extend that care to the health care team and then bring in extra knowledge. And she's also wanting to learn herself, which I appreciate. Site-C:P7*

2. The importance of time

Rushed consultations were often perceived as disrespectful, dismissiveness, or inattentive: “*If they’re rushed, they feel like they don’t matter.*” Site-A:P3. A sense of connection was fostered when GPs demonstrated genuine listening, took time to understand patients’ experiences, and provided continuity of care.

> *One that actually really listens and takes the time to understand where you’re coming from and what your pain is.* Site-B:P5
> *At the end of the day, it's just about being a good doctor…show that initiative that you want to be here…you've got to have that empathy and show that you want to work.* Site-A:P5
>
> *And got tired of seeing different doctors every time you go there and explaining everything to them every time you go…I'm sorry, but you don't want to go over it all the time. It's really hard work and to remember everything. Site-C:P4*

Participants also appreciated GPs who were approachable and flexible in their communication, pacing and allocation of time: “*Sometimes you just want to get in and get out. You don't really want to chit chat”.* Site-C:P7

3. Trusting and caring partnership

There was substantial thematic overlap between the trusting and caring partnership and attitudes, suggesting these elements are closely related.

Trust was a critical foundation of the patient-GP relationship, shaping whether participants felt safe, supported, and willing to engage in care. For many, trust meant being treated with compassion and without judgement, especially in moments of vulnerability or distress. As one participant explained:

> *Your patients can trust and feel comfortable around you and not feel judged from their past doings… Be understanding and to not just palm them off to see your next patient or to see another doctor because you don't have time to investigate what's happening and what's going on. Make sure they know that you are there for them—whether it be having a meltdown or you don't feel good or anything like that, just make sure you're okay. Site-C:D12*

Participants described trust as linked to being heard, taken seriously, and not brushed off with superficial care. When that trust was absent, feelings of safety and care where compromised:

> *They listen. And if you don't feel like you're listened to, and they've given you a Band-Aid for something that's been really bothering you and you don't feel like you're cared for, you don't feel safe. You know, we trust these doctors. If you can't trust your doctor, who can you trust? Site-A:P6*

The consequence of broken trust could be long-lasting, particularly for those who had experienced trauma or prior breaches of trust. One participant recounted how a GP's failure to listen during a critical time created a deep rupture in her willingness to seek care:

> *I was forced into having [my baby] by her father's choice, not mine. And my GP didn't listen to me, listened to him. And so, since then…it's taken a while to actually physically put my trust back into a GP.* Site-B:P1

She went on to explain how trust was gradually rebuilt through a GP who offered consistent, personalised and compassionate care:

> *They listened to what I needed and how I need it and the mental capacity that I was under…I wasn't able to function without having to see my GP on a regular basis.* Site-B:P1

4. Communication skills

Participants emphasised the importance of active listening, adopting a conversational or clinical yarning approach during consultations, and avoiding medical jargon.

Active listening

Active listening, feeling genuinely heard and not dismissed, was repeatedly stressed as critical in care. As one participant succinctly expressed:

> *You know, someone that listens. The whole reason why we got two ears and one mouth, this is it twice as much listening as talking. Some people do it the other way around. Shut up.* Site-D:P1

Others reinforced that without genuine listening, consultations feel futile:

> *If they don't listen, you're wasting your time*. Site-B:P6
>
> *Listen—it's all that it comes down to— listen…That's half the reason I didn't come here for a long time… What's the point of wasting my time coming up here if someone's not going to fucking listen to me.* Site-A:P10
>
> *Actually, feel like you're being heard and not just brushed off.* Site-C:P6

Participants also highlighted the importance of being accepted and heard as whole individuals, beyond stereotypes or assumptions based on identity:

> *Listening to me and taking on what I'm trying to say is a big thing for me because I've been dismissed quite a bit in my life with different things.*

> *Just listening and not judge the skin colour or think that you haven't got the skin colour.* Site-D:P6

Moreover, effective GPs were described as those capable of ‘reading between the lines’ to identify underlying issues patients may not openly share:

> *A good GP should be able to identify things that might be going on, that people are not talking about, and have the skills to try and tease that out of people.* Site-C:P12

Conversational or clinical yarning approach to the consultation

Participants valued a relaxed, conversational or yarning approach to consultations and recommended beginning with a simple greeting and informal conversation:

> *I just think greeting is the biggest thing: “G’day Mate” or “Hello. Hello”.* Site-A:P23

> *I guess just being greeted and asking how I'm going or how my day is. Just like a general acknowledgement, not just “What can I do for you today?”* Site-C:P6

> *Just having a conversation—like yarning more, just having a yarn. Like, “How’s your day?” ...and a little laugh. Cause it make you get nervous when you go to the doctor, then it's good to have... you just relax a bit more.* Site-D:P5

The yarning approach also involved taking time to ask about the person’s life in general, rather than rushing to a diagnosis:

> *The doctor actually takes time to ask a bit about me. It doesn't necessarily have to be about my culture. It might be about something in general that's*

> *just besides the medical point. You know, he's not making a diagnosis straight away - just friendly, 'hello how are you going', introduce himself, 'I'm from such and such'. Just things like that, because it is just a general conversation.* Site-A:P33

Participants expressed mixed views on being asked about their connection to culture and Country as part of this yarning conversation. For some, being asked about their mob or totem was seen as a respectful gesture of interest:

> *Don't be frightened to ask the question, "Where do you come from? What's your totem for your place? Or do you know your totem?" Ask them. But don't just ask them to have conversation, ask them because you actually care, and you want to find out.* Site-A:P32

Others described how, in trusted relationships, cultural identity often emerged naturally:

> *Well, it can come up without being asked like that…if you're with a GP that is really good, and you just start talking, it will come out.* Site-A:P21

However, several participants found these questions distressing, particularly when asked insensitively or without context. Some shared that being asked about their mob or heritage could be deeply painful, especially when they lacked access to that information due to past trauma or family separation: "*I mean, you make me cry, sorry, I don't know my mob*" (Site-B:P6): "*It probably would make me uncomfortable, because I wouldn't be able to answer it*" (Site-D:P8).

Others described the question as too personal, invasive, racist, or judgmental—particularly for light-skinned Aboriginal people who felt the question was used to question or validate their identity:

> *It’s kind of personal. But if they do ask, they can ask. But I don’t think you should be put in that position at all.* Site-D:P10

Other key behaviours that supported a clinical yarning approach included eye contact, which signalled to participants that the GP is listening and interested.

> *Eye contact’s important because it shows that he's listening, he's understanding, he's interested in you as a person*. Site-A:P13

Participants had mixed views on the use of silence in consultations. Some participants appreciated brief silences as opportunities to pause, think, and process what was discussed. “*It gives you a chance to think before you speak. And also, if the doctor's telling you something, to understand what, to process what they're telling you*” Site-B:P9. Others found silence acceptable when clearly linked to purposeful tasks, such as note-taking or clinical reasoning. For many, unacknowledged silence was unsettling and led to discomfort or distress. Silence was variably described as “awkward”, “uncomfortable”, “embarrassing”, “weird”, “shameful”, or emotionally overwhelming. Some participants interpreted silence as a negative signal—that something was seriously wrong. In some cases, silence prompted participants to disengage entirely, with one stating they saw it as a cue to leave.

> *Depends on what type of silence it is— whether it's a comfortable silence or that—if he's writing stuff, if he's said, “Look, I need to write these”… If he's nice to you, it's a comfortable silence if he's an asshole to you, well, it's a very uncomfortable silence, you know what I mean?* Site-A:P31

> *Well, it makes me think that "What's going through their head? Are they not telling me something? Hiding something?” I'm not a person for silence. So, if I go in and my doctor's just sitting there, I'll say to him, "What's wrong? Is there anything wrong?" I don't like silence.* Site-A:P12

Use simple language and avoiding medical jargon

Participants strongly emphasised the importance of using plain, accessible language in consultations.

> *I find the best thing when I walk into a GP's room is that they just talk to you as a normal human being. They don't get there and say great big words that a lot of people don't understand.* Site-A:P21

Participants wanted GPs to speak in ways that made them feel respected, understood, and included in decision-making.

> *You feel like you want to be heard and that they speak to you in layman's terms that you understand instead of using the big medical terminology…I have had an experience just lately with a doctor who I felt he was trying to see whether I was an imbecile or whether I was educated, or whether I would just accept what he said…It's just lovely how like you're sitting relaxed face to face, letting the patient do the talking. And then maybe asking questions after instead of interrupting in between and not letting you finish your sentence.* Site-A:P23

5. Aiming for positive outcomes

Many participants spoke about feeling excluded from their own care, describing an absence of empowerment, shared decision-making, and genuine involvement in consultations. Several described encounters where they felt disrespected, invalidated, or marginalised—experiences that often led them to withdraw from care.

Lack of cultural recognition and identity invalidation were recurring concerns.

> *I didn't want to be judged because I don't fit the stereotype [dark skin] as some other people...I didn't want to feel like a fraud, even though I know that I'm not.* Site-C:P9

Rudeness and emotional detachment also contributed to feelings of being unwelcome or devalued.

> *He's just so blunt. He just didn't seem like he wanted to be there doing what he was doing. He would just be like, "Oh. Yep, yep, yep, yep" ...It's like he just wanted to get you in and get you out.* Site-D:P13

Participants reported being dismissed when raising health concerns, which significantly undermined trust.

> [*I] kept on saying, "There's something wrong, there's something wrong with me". And the doctor just blew me off and all that stuff. I believe that everyone knows their body better than anyone else. And when they say something's wrong, you got to listen to them. But this doctor blew me off and another doctor did the same just didn't want to know me.* Site-C:P3

> *I told them I had a really bad backache, and they said, "There's nothing wrong with your back". And I told them, "There is something wrong with my back. It's not your back, it's my back. I know what I feel". And they said "No, there's nothing wrong with your back", and then they asked me to leave.* Site-B:P5

Communication breakdowns were another common barrier, with participants describing being ignored, misunderstood or spoken down to.

> *When they haven't been listening to me, I just get another doctor and find someone that does listen to me.* Site-A:P10

> *Everything what she was doing and saying just made me feel like shit. And I just felt like crying… I felt like I couldn't open up or share that to her. So, then I just didn't bother. And then she asked me, "Oh, why? What can I do for you today?" Then when she tried to go into it, I said, "No, sorry for wasting your time" and I just left. Site-A:JointInterview2*

Participants often defined good outcomes in relational and holistic terms—"feeling heard," "being respected," "leaving with less worry."   Participants described valuing GPs who offered choice, clearly explained available options, and advocated for their access to appropriate care and services.

Conversely, when shared decision-making was absent, participants reported feeling disempowered or misunderstood. One participant recounted an interaction where they had expected a collaborative conversation about treatment options but instead encountered a direct, inflexible approach.

> *He made me feel very uncomfortable in the way he interacted with me…He made me feel like, "What's wrong with you?" … I was told to go and see him, and he would be able to talk about all of these different things that I could make decisions on with regards to my health…But in his eyes, he was like, "You're here to get this done and that's what you're getting done. Why are you here?"* Site-B:P7

6. Understanding the whole person

Participants appreciated GPs who acknowledged them as individuals and respected their cultural identity.

> *Look, I have a very good doctor, so I'm going to use her as an example. First and foremost, she cares about me and my well-being, and my family. And sits and talks like this [indicates sitting face-to-face and relaxed with*

> *the interviewer]- not, 'What's the matter with you today?" It's about the person…If you care about them it makes a big difference and I don't think it's just an Aboriginal thing -I think it's an everybody thing…That this was a doctor that saw the person before the illness and then could see the illness for that person.* Site-C:P4

For some, culture was central to the consultation; others preferred it not shape their care but still expected respect for their identity.

> *I don't want my culture to affect the way she treats me… "Oh, I'm Aboriginal" and then they're like, "Oh, so does that mean that this happens?" And I was like, "Well, yeah, but that doesn't change how you have to treat me".* Site-C:P1

> *They've taken the time to get to know me as a person - not only just asks about my health issues…Maybe ask a bit about my culture, but mainly when they talk about my health issues—talk in general and understand my history when it comes to health and how I've dealt with things. And when you talk just in general to someone—like you having a conversation—it's not just about my health…* Site-A:P33

Several noted that low health literacy, limited education, or past trauma contributed to their fear or discomfort in consultations. GPs who considered broader life factors, like financial hardship or caregiving responsibilities, were valued for providing holistic care.

> *I was taking my friend's tablets because I couldn't afford my medication, and I refused to tell him that I was taking [them].* Site-D:P9

> *[A good GP] takes in the fact that most people who have a cultural background don't have the capacity to be able to get to medical appointments. If you have kids…they will help you drop them off.* Site-B:P4

When care was not holistic or personalised, participants felt dismissed or reduced to a diagnosis. Some described frustration with a narrow, medication-focussed approach.

> *I was going through depression. And I was ashamed. Didn't want to admit it. This doctor tried to put me on medication. Didn't I go off. That's disrespectful to me being Black. I said, "Don't you think that you could have asked me who I am? Really? What do I do? What about meditation? Did you ever ask me about that? No, you didn't. Did you just jump to the conclusion you wanted me to take the drugs? You disrespected me. That's bad practice". Doctors always want to give out drugs, drugs, drugs. Ask the person - 'What do you do?' 'What   do you like doing?'.* Site-A:P5

Spirituality is often considered a part of holistic care for Aboriginal and Torres Strait Islander patients. Spirituality was seen as deeply personal, with most participants agreeing that it should not be presumed as part of clinical care unless raised by the patient.

> *Only if you mention it to them. But if you don't say nothing well, then just treat me like anybody else. As long as I look after me and keep me alive, I'm happy.* Site-A:P11

7. Seeing the patient as a unique person

For many participants, being seen as a unique person meant being treated with humanity and dignity—not as a number or stereotype: "*Just treat you as a human being. Not as a number"* Site-C:P3.

At the same time, many participants expressed a desire to be treated equally to non-Indigenous patients—emphasising fairness, respect and a universal standard of care that recognised their humanity without bias or judgement.

> *I believe in equality, black, white, brindle or otherwise, disabled, whatever…Mine is equality for everybody.* Site-A:P23

> *Just treat you as a human being. Not as a number…We are all the same…we all bleed the same and all bloody go to the toilet and wipe out the arse the same. To me no one's above you or below you.* Site-C:P3

8. Considering the system and helps access care

Participants reinforced the need for systems-aware GPs who help navigate complex services and advocate for access, particularly in the context of structural barriers and historical disadvantage. Most participants value GPs having knowledge of Closing the Gap initiatives to improve health outcomes. Others prioritized clinical knowledge or thought this task was best done by the health care team.

> *Closing the Gap obviously helps a lot of Indigenous people that can't afford prescriptions or anything like that… and if your patient is Indigenous to have them on that kind of program.* Site-D:P12

> *It is very important that they've got a good knowledge of all these incentives and schemes to help improve Indigenous health. Saying that, I do know that there's so much for GPs to try and remember.* Site-C:P7

> *I've been into GP practices where they haven't even asked if I've been Aboriginal…and then I don't get CTG, so I'm paying full price…Knowing about what's available for our Mob, for their care.* Site-D:P2

> *A good doctor's help me out like - give me lifts, stuff like that.* Site-A:P20

9. Optimising the environment

This theme highlights the critical role of the general practice environment in shaping safe and respectful care. Participants described visual cues in the clinical environment - such as Aboriginal and Torres Strait Islander artwork, background television, and welcoming reception staff—as important to shaping self and respect care.

> *That I can see things in their room that I connect with...Aboriginal and Torres Strait Islander pamphlets, artwork. Anything that I know in this space - I belong here.* Site-D:P2

> *The feeling around you—the TV going, other information that you can read, paintings...* Site-C:P4

> *If there's cultural stuff or cultural paintings or some kind of artifact or things in the office, I know straight away that they've dealt with Indigenous people.* Site-A:P33

In contrast, negative experiences with clinic staff could undermine the sense of safety:

> *They treated me like a bag of dirt—the receptionist. I asked a question. She must've been having a bad day because she just went off.* Site-C:P3

Participants also highlighted that environmental safety included ensuring privacy, confidentiality, and informed consent—particularly during physical examinations and sensitive discussions.

> *Privacy is very important. If they're doing any medical examination, make sure the door is locked ...and the screen pulled. because a lot of Murris are self-conscious about their body, you know?* Site-A:P31

> *I do feel safe, and I feel that my privacy is being respected—the GP shuts the door, for example, when you come in to for the consultation.* Site-C:P10

> *Knowing that everything is confidential and that it's a safe place to talk about anything that concerns me.* Site-A:P31

> *A closed door. I like that there's always asking for consent before doing something.* Site-C:P9

There was also a strong theme that involvement of family or others in a consultation should only occur with explicit consent. While some participants valued family support, others stressed the importance of autonomy and personal privacy:

> *Only if our family wants us. If they need us to be there—we might be outside...Family is the most important thing to us. So, it's whether your family wants you to be there or not.* Site-A:P33

> *No, no, no. I don't want my family. I'm quite capable of handling things myself*. Site-A:P31

> *No, no, I believe that that's private.* Site-D:P4

Discussion

Our findings suggest that PCC, particularly its emphasis on adaptability to individual needs and the incorporation of personal values and preferences, can actively support the delivery of culturally safe care when enacted with critical reflection, humility and attention to power differentials. This is not to dilute or rebrand cultural safety, but rather to highlight that a relational, flexible and ethically grounded approach may offer a universally applicable model of practice. Such an approach could provide clear guidance to GPs, including those who may not regularly engage with Aboriginal and Torres Strait Islander patients but are nevertheless expected to demonstrate cultural safety in assessments or exams.

Core elements of PCC like engagement, relationship, communication, shared decision-making, holistic and individualized focus (14-17) aligned closely with the key concepts of cultural safety as defined by Ahpra (3) and reflected what participants valued in GP consultations. While participants described diverse preferences in how these principles were enacted in practice, no fundamental conceptual conflicts between PCC and cultural safety were identified. The diversity of participant perspectives underscored that culturally safe care cannot follow a one-size-fits-all or tick-box approach, highlighting the need for assessment strategies capable of capturing multiple, sometimes divergent, experiences of cultural safety.

However, while PCC offers a framework for personalising and humanising care, it perhaps is not sufficient on its own to ensure culturally safe practice. PCC tends to centre on interpersonal interactions and patient satisfaction, whereas cultural safety requires a deeper structural lens, including attention to systemic inequities and power differentials. It demands reflexivity from GPs—a critical engagement with power dynamics, privilege, and historical context, and a commitment to health equity (3). Importantly, it positions patients as the ultimate arbiters of what constitutes “safe” care. This shift in epistemology—from GP-delivered competence to patient-determined safety—marks a critical departure between PCC and cultural safety. It shifts the locus of control from the provider to the patient and reorients care toward justice, equity, and respect for cultural identity and lived experience. Existing PCC tools such as PREMs and mini-Clinical Evaluation Exercises (mini-CEX), often fail to capture this dimension: they may assess whether a doctor listens attentively, but not whether the patient felt stereotyped or misunderstood due to cultural assumptions. Similarly, it may evaluate continuity of care without interrogating whether that continuity fostered a culturally respectful and trusting relationship. This highlights a critical gap in current assessment frameworks that limits their capacity to evaluate culturally safe practice fully.

PCC, as currently practised, often emphasises the clinical relationship and shared decision-making within a biomedical framework (34). It is generally GP-led and embedded in existing healthcare structures. In contrast, person-centred care expands this focus beyond the immediate clinical context, recognising the patient as a person embedded within a broader social, cultural and historical context (34). It incorporates attention to the determinants of health, relationships, lived experiences, and the person’s own sense of identity and well-being. In this sense, person-centred care better aligns with the long established ACCHO principles (including holistic, flexible and responsive approaches to care, relationship building, advocacy, health promotion and accessibility) (35).

That said, we must be cautious not to oversimplify cultural safety by obscuring its deeper intent. Cultural safety, particularly for Aboriginal and Torres Strait Islander communities, is about more than person-centred care, clinical competence or being “nice and kind”--it also requires consideration of systemic inequalities, such as reduced access to care, lower education, employment and incomes (36). In addition, GPs must be aware of one’s own power and privilege and commit to a decolonising approach to care. Culturally safe care is not an optional or additional feature of quality healthcare, it is fundamental. Without cultural safety, the core aims of PCC, such as building trust, fostering genuine partnerships, and improving health outcomes, cannot be fully achieved.

Our study highlighted several key considerations for delivering culturally safe care to Aboriginal and Torres Strait Islander peoples:

- Recognition that cultural safety cannot follow a one-size-fits all approach and is context dependent. Consistent with PCC, care must be flexible, responsive and honour the unique experiences and needs of each individual.
- Avoidance of stereotyping and judgement. GPs must provide personalised care that considers the influence of Aboriginal identity, social determinants of health, and systemic racism on healthcare access and outcomes.
- GPs must remain critically aware of their own biases and the power dynamics inherent in their role. Active listening, a conversational approach, relaxed body posture and an attitude of humility help patients feel more empowered.
- Identity as an Aboriginal and Torres Strait Islander person must be respected—regardless of physical appearance, cultural practices and beliefs. Further, identity is dynamic and has varying impact or influence on an individual’s worldview, behaviours and engagement with health services.
- Clinical competence is inseparable from PCC and cultural safety.
- Sufficient consultation time is essential for building trust, supporting effective communication, and enabling culturally safe interactions.
- Clear communication preferences included appropriate eye contact as well as avoiding both silence and the use of medical jargon.

- Attention to privacy, informed consent (including for involvement of others in a consultation), confidentiality and ensuring the clinical space feels welcoming for Aboriginal and Torres Strait Islander peoples.

Implications for Practice and Policy

Integrating PCC with cultural safety as a core component may enable educators and GP supervisors to focus on teaching and assessing a single, coherent model of care. By emphasizing culturally safe practices within the PCC framework, learners may be better able to develop a deep, transferable understanding of how to deliver respectful and responsive care. Mastering this integrated approach with one population has potential to create a strong foundation that can be applied effectively across diverse population groups. Dr Louis Peachey, one of Australia’s first university trained Indigenous doctors, describes how a consultation that is safe for an Aboriginal and Torres Strait Islander person is probably going to be safe for everybody else (37).

An intentional strategy of explicitly integrating culturally safe practice within the existing PCC teaching and assessment frameworks may support more efficient progression through the stages of skill acquisition (38), ultimately enabling learners to achieve higher levels of competence and expertise in delivering culturally responsive PCC. Furthermore, gaining deeper insight into what individuals value in a GP consultation can inform refinement of PREMs (12, 25), as well as enhance feedback and assessment methods used in learner evaluation.

Existing PCC tools could be strengthened by incorporating specific cultural safety domains. For example, PREMs might include items such as: “I felt respected as an Aboriginal and/or Torres Strait Islander person,” “I did not feel judged or stereotyped,” and “My cultural identity and experiences were acknowledged where relevant.” Similarly, while the ultimate assessment of cultural safety should be determined by the patient, supervisor-based tools such as the mini-CEX could capture observable behaviours including critical reflection on power and bias, avoidance of assumptions, acknowledgement of social and historical context, and use of communication strategies that foster trust and shared understanding.

Next steps

The next phase uses a Delphi process to identify assessable components of culturally safe, person-centred care, followed by development and validation of a model and assessment tool within simulated consultations.

While our findings offer insights into culturally safe, person-centred care, it is too early to make specific policy recommendations for general practice training or Ahpra standards. Once the model and assessment tool have been validated in practice, the results may inform future guidance on integrating cultural safety into professional standards and accreditation processes.

Limitations

Member checking was undertaken with two participants only. Although the research was confined to a specific geographic area, which may limit its generalisability to other parts of Australia or internationally, its credibility was enhanced through presentation at both national and international forums focussed on general practice and Indigenous health. These settings provided opportunities for critical engagement from diverse stakeholders, whose feedback help to validate the study’s analysis and demonstrated its relevance to wider clinical and cultural contexts.

Conclusion

Given the conceptual overlap, PCC offers a promising base from which to teach, assess and promote culturally safe care—but only if it is explicitly expanded to incorporate the principles of cultural safety developed by Aboriginal and Torres Strait Islander communities. This includes attention to the GP’s attitude, embedding care within its broader socio-political context, addressing systemic racism and power imbalances, and developing the skills needed to identify and act upon the ongoing effects of colonisation on health and healthcare access.

The foundational values of PCC are compatible with the ACCHO model of care. Recognising this connection allows healthcare systems to build on a proven, culturally grounded model rather than duplicating efforts. For medical education, explicitly integrating cultural safety into PCC frameworks provides a coherent, practical approach for teaching and assessing culturally responsive practice, ensuring learners develop the knowledge, skills, and reflective capacity necessary to deliver care that is both person-centred and culturally safe.

Declarations

Ethics approval and consent to participate: All participants provided written informed consent. Ethics approval was granted by the James Cook University Human Research Ethics Committee (H8296). The study adhered with the Helsinki Declaration.

Consent for publication: not applicable

Availability of data and materials: The data from this study cannot be shared publicly to protect participant privacy and respect cultural protocols, as advised by the community advisory group.

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Appendix 1: Common themes of patient and person-centred care, and culturally safe care

Theme	**Scholl et al. (17)**	**Brickley et al. (15)**	**Eklund et al. (16)**	**Culturally safe care (3)**
1.Essential characteristic of the GP	P: Attitudes (e.g. empathy, respect, honesty, self-reflectiveness) and medical competency	Finding common ground: empathy,	*Empathy*: Compassionate, emotional support, understands patient *Respect*s beliefs and values. Supports dignity.	Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism;
2. The importance of time	E: Access to care	Experiencing time: Allocate enough time, continuity of care	*Engagement* Allocates time, is present and committed	Accessible and responsive healthcare
3.Trusting and caring partnership	P: Clinician-patient relationship:	Finding common ground: Build trust and	*Relationship* Builds partnership, mutual	-

	Trusting and caring partnership	form partnership, empathy, collaborate	trust, therapeutic relationship	
4. Communication skills	E: Communication	Understanding the whole person: Listens to the lived experience	*Communication*	-
5.Aiming for positive outcomes	A: Patient information, involvement in care, patient empowerment, Involvement of family and friends	Aiming for positive outcomes	*Shared decision-making*: Empowerment, autonomy, patient involved in treatment	Recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community;
6.Understanding the whole person	P: Biopsychosocial perspective: The patient as a whole person	Understanding the whole person: Comprehend patient's characteristics, values, capabilities,	*Holistic focus*: Non-medical issues are considered relevant, the context has impact	Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which

		perspectives, preferences and medical issues		impact individual and community health; Provide care that is holistic, free of bias and racism;
7.Sees the patient as a unique person	P: Patient as a unique person: Recognition of each patient's needs, preferences, values, feelings, beliefs, concerns and ideas, and expectation.	Finding common ground: Discuss care expectations	*Individualized focus*: Consider specific aspect of patient's life, preferences are considered relevant	Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health;
8.Considers the system and helps access care	E: Integration of medical and non-medical care, coordination and continuity of care,	Considering the system and collaborating in care	*Coordinated care* across the health system, professions and across time	Recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the

	access to care, team work and team building,			individual, family and community;
9.Optimising the environment	A: Physical and emotional support	Optimising the general practice environment	-	Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues

Summary:

Essential characteristics of the GP – particularly empathy, respect, self-reflection and clinical competence – consistently emerge as foundational to person and PCC (15-17), aligning closing with the principles of culturally safe care that emphasise recognising and addressing bias, racism and the need for holistic, respectful engagement (3).

The importance of time - Allocating sufficient time and ensuring continuity of care is core to all models and reflects broader GP commitment to engagement, accessibility, and responsiveness (15-17).

Trusting and caring partnership emphasises the importance of a strong patient-GP relationship built on empathy, collaboration and mutual trust (15-17). Cultural safety recognises that a patient's trust in the system may be affected by past trauma or discrimination, and it seeks to create a safe space for care (3).

Communication skills– particularly the importance of attentive, empathetic listening in understanding the whole person. While not explicitly named, listening can be considered within the skills and practising behaviours associated with cultural safety, as outlined in the Ahpra definition (3).

Aiming for positive outcomes - Brickley (14, 15) identify 'aiming for positive outcomes', as a key domain of PCC, while Scholl (17) and Ecklund (16) reflect a shared emphasis on patient empowerment, shared decision-making, and involvement in care. These concepts align closely with culturally safe care, which centres on self-determination in achieving meaningful health outcomes (3).

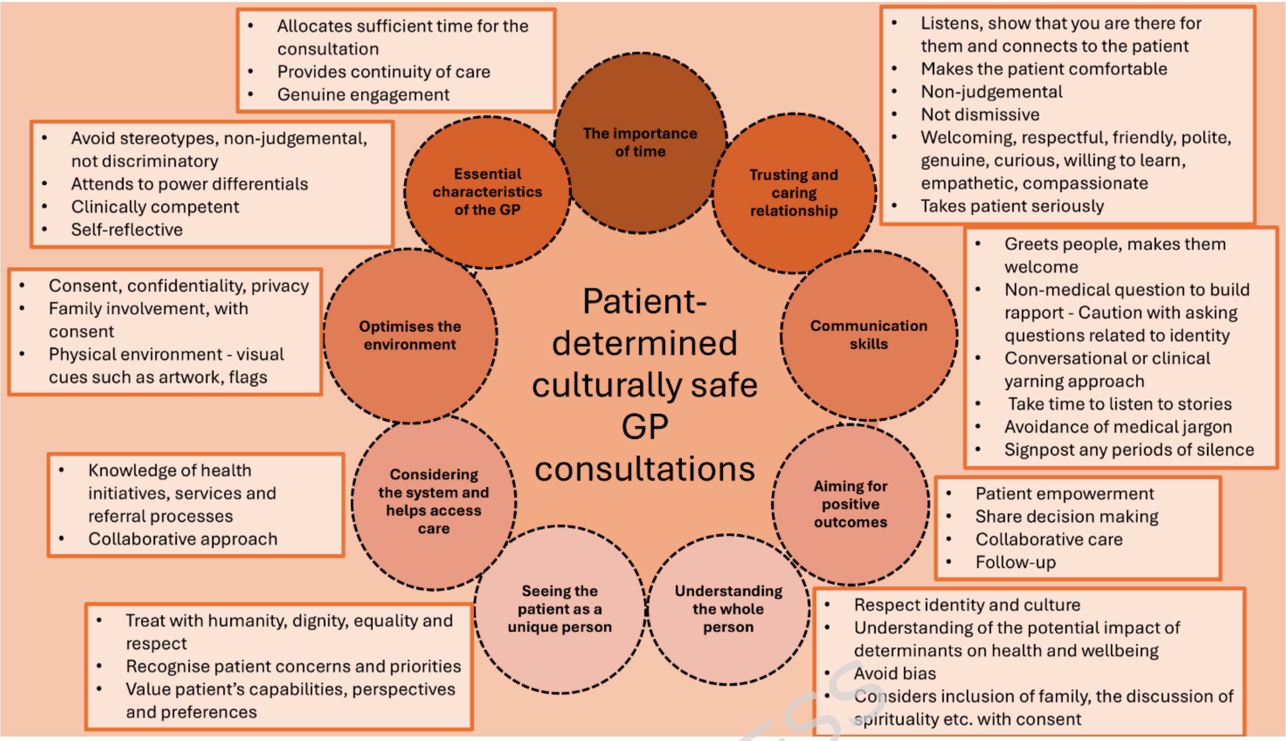
Understanding the whole person - PCC (14-17) recognises that effective care extends beyond clinical symptoms to include personal values, social context, and broader life circumstances. This holistic perspective aligns closely with culturally safe care, which acknowledges the ongoing impacts of colonisation and the social, cultural, and economic determinants of health (3).

Seeing the patient as a unique person - A central component across models of PCC is the recognition of each patient as a unique individual, whose preferences, values, and life context must inform care (14-17). Culturally safe care builds on this by addressing systemic racism and interpersonal biases and acknowledging the way broader historical and social realities shape individual health experiences (3).

Considering the system and helps access care All models emphasise the importance of coordinated, integrated care that bridges medical and non-medical needs, ensures continuity across time and services, and supports access through collaboration and teamwork (14-17).

Optimises the environment is unique to Brickley’s model (15).

Figure 1:



- Allocates sufficient time for the consultation
- Provides continuity of care
- Genuine engagement

- Listens, show that you are there for them and connects to the patient
- Makes the patient comfortable
- Non-judgemental
- Not dismissive
- Welcoming, respectful, friendly, polite, genuine, curious, willing to learn, empathetic, compassionate
- Takes patient seriously

- Greets people, makes them welcome
- Non-medical question to build rapport - Caution with asking questions related to identity
- Conversational or clinical yarning approach
- Take time to listen to stories
- Avoidance of medical jargon
- Signpost any periods of silence

- Patient empowerment
- Share decision making
- Collaborative care
- Follow-up

- Respect identity and culture
- Understanding of the potential impact of determinants on health and wellbeing
- Avoid bias
- Considers inclusion of family, the discussion of spirituality etc. with consent

- Treat with humanity, dignity, equality and respect
- Recognise patient concerns and priorities
- Value patient’s capabilities, perspectives and preferences

- Knowledge of health initiatives, services and referral processes
- Collaborative approach

- Consent, confidentiality, privacy
- Family involvement, with consent
- Physical environment - visual cues such as artwork, flags

- Avoid stereotypes, non-judgemental, not discriminatory
- Attends to power differentials
- Clinically competent
- Self-reflective

Table 1: Participant characteristics

Participants		**Total**	**Site A** **N=33**	**Site B** **N=12**	**Site C** **N=12**	**Site D** **N=13**
Total population (Indigenous population %)		NA	3971 (11.5%)	173204 (4.8%)	NA	63515 (6.2%)
Location classification		NA	Very remote community	Regional centre	NA	Large rural town
Age	8-34	26 (37%)	9 (27%)	4 (33%)	6 (50%)	7 (54%)
	35-54	21 (30%)	7 (21%)	7 (58%)	2 (17%)	5 (39%)
	55+	23 (33%)	17 (52%)	1 (8%)	4 (33%)	1 (8%)
Gender	Male	17 (24%)	8 (24%)	5 (42%)	2 (17%)	2 (15%)
	Female	53 (76%)	25 (76%)	7 (58%)	10 (83%)	11 (85%)
Education	Year 9 or below	12 (17%)	10 (30%)	0 (0%)	1 (8%)	1 (8%)
	Year 10 -12	31 (44%)	14 (42%)	4 (33%)	5 (42%)	8 (61%)
	Certificate III, IV or diploma	19 (28%)	8 (23%)	7 (59%)	1 (8%)	3 (23%)
	Bachelor and above	8 (11%)	1 (3%)	1 (8%)	5 (42%)	1 (8%)
	Employed	34 (49%)	10 (30%)	8 (67%)	11 (92%)	5 (38%)

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Employment	Unemployed	25 (36%)	13 (39%)	4 (33%)	0 (0%)	8 (62%)
	Retired	11 (16%)	10 (30%)	0 (0%)	1 (8%)	0 (0%)
Income	Low	50 (72%)	27(82%)	6 (50%)	5 (42%)	12 (92%)
	Medium	19 (27%)	1 (18%)	6 (50%)	6 (50%)	1 (8%)
	Not stated	1 (1%)	0 (0%)	0 (0%)	1 (8%)	0 (0%)