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Towards assessment of culturally safe general practitioners: co-designing with Aboriginal and Torres Strait Islander peoples' perspectives, the Calgary–Cambridge guide and clinical yarning

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ABSTRACT

Background. Cultural safety is a key component of quality general practice for Aboriginal and Torres Strait Islander peoples; however, few tools exist to assess this from the patient's perspective. This study aimed to explore the qualities of a general practitioner (GP) that support culturally safe consultations, as described by Aboriginal and Torres Strait Islander peoples, and to examine how these align with two consultation models: the Calgary–Cambridge Guide and clinical yarning. **Methods.** A mixed methods approach was used, including a survey, qualitative interviews and a modified nominal group technique (mNGT). Participants were Aboriginal and Torres Strait Islander peoples who had previously engaged with general practice care. Data were both described and analysed thematically. **Results.** In total, 131 Aboriginal and Torres Strait Islander peoples participated (70 in the survey and interview; 43 in mNGT to validate the findings; and 18 in three separate mNGTs to rate desirable attributes of a GP). Participants identified several qualities underpinning a safe GP consultation. Within the top five attributes in the mNGT were universal skills – clinical competence, avoidance of jargon and attentive listening – alongside welcoming patients with a greeting and avoiding stereotyping. Although there was strong emphasis on respectful, individualised care, preferences varied significantly, highlighting the limitations of a generic approach to consultation skills. Some findings challenged core assumptions regarding clinical yarning and elements of cultural safety training. **Conclusion.** We propose a refined, integrated consultation model that enhances the Calgary–Cambridge Guide with relational elements of the social yarn, particularly during initiation of the consultation. This integrated model, grounded in Aboriginal and Torres Strait Islander peoples' perspectives yet familiar to GPs and academics, offers a promising foundation for culturally safe practice and assessment, with potential applicability across other diverse populations.

Keywords: Aboriginal and Torres Strait Islander health, Australia, Calgary–Cambridge guide, clinical yarning, cultural safety, equity, general practice, Indigenous health care.

Introduction

As consultations with GPs are often a patient's first contact with the healthcare system (Kelaher *et al.* 2010), ensuring accessibility, safety and quality of care is critical to improving the health and wellbeing of patients, their families, and carers. For Aboriginal and Torres Strait Islander peoples, encounters with GPs may be influenced by not only experiences of racism and discrimination (Paradies *et al.* 2015), but also by the enduring impacts of colonisation, including dispossession, cultural disruption and intergenerational trauma (Durey and Thompson 2012). Providing culturally safe consultations is therefore not only a healthcare imperative, but also a matter of social justice, honouring identity, upholding values, and protecting rights for Aboriginal and Torres Strait Islander peoples (De Zilva *et al.* 2022; Moloney and Stuart 2025). However, identification and assessment of GP attributes that support culturally safe care remain complex and evolving, shaped by historical injustices, systemic inequities, and continued efforts to embed culturally safe care within medical education and healthcare practices.

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Consultation models (Mehay *et al.* 2012), together with established principles of patient-centred care, such as respect for patient values, shared decision-making and responsiveness to individual needs, have long underpinned assessments of general clinical competence (Brickley *et al.* 2020; Manalastas *et al.* 2021). A variety of consultation models are available in general practice, including task- or process-orientated approaches (Roth and Willems 2022), such as the Calgary–Cambridge Guide (CCG; Kurtz *et al.* 2003), which outlines the key phases of the medical interview, and emphasises effective communication as central to clinical practice.

However, these models rarely address cultural safety, and are not explored or validated for Aboriginal and Torres Strait Islander peoples (Zill *et al.* 2014; Brouwers *et al.* 2017; Ahmed *et al.* 2018). Critically, current assessment processes and consultation models are often developed from the perspective of the dominant culture, and tend to exclude Aboriginal and Torres Strait Islander peoples' voices in defining and determining cultural safety (Australian Health Practitioner and Regulation Agency 2019). Furthermore, there is little research exploring and understanding how consultation models address cultural safety with Aboriginal and Torres Strait Islander peoples in general practice (Burke *et al.* 2022).

Lin *et al.* (2016) propose clinical yarning as a culturally secure, patient-centred approach to a consultation; however, 'secure' is used without further definition. The clinical yarning model comprises three stages: the social yarn (building rapport), the diagnostic yarn (exploring health concerns through narrative) and the collaborative management yarn (supporting shared decision-making; Lin *et al.* 2023). The clinical yarn emphasises active listening, and building a trusting relationship between patients and health professionals.

Clinical yarning has been considered similar to the CCG. Lin *et al.* (2023) mapped the key skills of clinical yarning to the CCG and identified that the clinical yarning approach placed a stronger emphasis on understanding a person's story through skills, such as 'finding common ground, sharing information about oneself, demonstrating awareness or knowledge of Aboriginal and Torres Strait Islander culture, the use of humour and responding to cues' (Lin *et al.* 2023). Similarly, in Aotearoa, New Zealand, the CCG has been adapted into the Meihana model to support communication with Māori patients (Pitama *et al.* 2017). McKivett *et al.* (2019) proposed a comparable framework for Aboriginal and Torres Strait Islander peoples.

We hypothesise that, like traditional consultation models, the clinical yarning model could serve as a framework for assessing cultural safety in GP consultations with Aboriginal and Torres Strait Islander peoples. This study explores Aboriginal and Torres Strait Islander peoples' perspectives on culturally safe GP consultations, examining whether participant-described attributes align with the CCG and/or clinical yarning frameworks.

Methods

This research used a mixed methods design incorporating semi-structured interviews, a survey and a modified nominal group technique (mNGT). The research protocol has been published (Brumpton *et al.* 2023); accordingly, methods are abbreviated in this paper. The study was guided by an Aboriginal Community Reference Group comprising Aboriginal staff from an Aboriginal Medical Service (AMS) where KB and RW are based. Group members were identified through local leadership processes to ensure appropriate community representation, and provided advice on study design, recruitment strategies and interpretation of findings to ensure the research reflected community perspectives. Remuneration varied: some members volunteered, others were funded through project grants and some contributed in-kind as part of their salaried roles within the AMS. The study conduct and reporting were guided by the CONSIDER (Consolidated Criteria for Strengthening Reporting of Health Research Involving Indigenous Peoples) principles (Huria *et al.* 2019).

Study setting and population

Participants were Aboriginal and Torres Strait Islander adults who had accessed general practice care and could provide informed consent. Recruitment occurred through three community-controlled AMSs, a non-AMS general practice, and community networks in both regional and very remote settings across Queensland, Australia. AMSs were up to 750 km apart from each other. AMS staff facilitated recruitment by inviting individuals directly, typically during clinic appointments. At the non-AMS site, invitations were distributed via email. Snowball sampling supplemented recruitment, including participants from other non-AMS practices. Within the AMS, interviews were commonly scheduled to coincide with clinical appointments to minimise participant burden. The interviewer (HW) was embedded on-site throughout data collection to build rapport, foster trust and support culturally responsive engagement.

Data collection

An initial survey gathered demographic data, followed by semi-structured interviews conducted in person or, for three participants, by telephone. Interviewers had no prior connection to participants, and were deemed culturally safe by the Reference Group through previous interactions and pilot interviews. Interviews used a flexible guide based on the Australian Health Practitioner Regulation Agency's cultural safety definition (Australian Health Practitioner and Regulation Agency 2019). Participants ranked GP attributes and communication behaviours by importance and explained their choices. Data were analysed iteratively through coding and team discussions. Although the dataset provided sufficient

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depth to identify meaningful patterns, data collection continued to ensure all participants who wished to share their experiences were included. This approach facilitated reflexive consideration and the generation of rich, nuanced insights aligned with the research questions.

Four mNGT sessions were conducted. The first group validated findings from the interviews, whereas the other three prioritised GP attributes for culturally safe care identified by the first group and the research team. Participants ranked attributes from 1 (most important) to 10 (least important) during the session using a visible chart to promote transparency and shared agreement in how contributions were represented.

The mNGT followed a simplified structure of silent idea generation, round robin sharing, clarification, ranking and group deliberation (McMillan *et al.* 2016). To ensure cultural responsiveness, several adaptations were made. The conventional discussion phase was replaced with a yarning process, enabling relational and informal dialogue consistent with Indigenous research methodologies (Bessarab and Ng'andu 2010). Two participants were involved in both the interviews and mNGT sessions.

Data analysis

Participant demographic and mNGT data were summarised descriptively, and interview transcripts thematically analysed applying Braun and Clarke's (2023) approach. Using the Australian Health Practitioner Regulation Agency definition of cultural safety, an initial coding framework was applied deductively by KB in NVivo (Lumivero), followed by an abductive approach to deepen analysis. HW reviewed a subset of the codes and themes, with regular team discussions and feedback from the Reference Group and conference presentations enhancing rigour. In a secondary analysis phase, data were re-coded using the CCG and clinical yarning frameworks.

Reflexivity

The principal investigator, KB, is an experienced GP academic working in a participating AMS. Her cultural heritage is uncertain and is impacted by the complexities surrounding Aboriginal identity within Australia (Carlson 2016). RW is an Aboriginal academic from Kunja Nations, RE is a senior researcher, and TS and HW are academic GPs. As a GP researcher, KB was aware of the potential link between cultural safety and communication skills, and remained reflexive throughout the analysis to ensure themes were grounded in participants' own accounts. Regular investigator team discussions and input from members of the Reference Group helped minimise bias and reduce the risk of imposing interpretations not supported by the data.

Ethics statement

Ethics approval was granted by the James Cook University Human Research Ethics Committee (H8296).

Results

Participants ($N = 70$) were recruited from four sites: Site A ($n = 33$; very remote community), Site B ($n = 12$; regional centre), Site C ($n = 12$; inner regional to very remote region) and Site D ($n = 13$; large rural town). Participants had diverse educational and socioeconomic experiences, providing important context for service engagement and health literacy rather than comparisons of capability or potential. Most participants were women (76%), aged 18–34 years (37%) and reported a low income (72%). In the very remote community, one-third had completed Year 9 or below.

In total, >29 h of data were collected from 61 individual interviews and four group interviews (2–3 participants each) lasting 7–66 min (average 27 min). Four mNGT groups followed the interviews, with 43 participants in the first group and 18 in the remaining three (6 men, 12 women, aged 18–60 years).

Quotes are labelled by site (A–D) and participant number (e.g. Site-A:P3); or by mNGT group. Sites A, B and D represent AMSs; Site C includes non-AMS general practices. Conversational phrases (e.g. 'you know', 'like') were removed for clarity. Two participants completed member checking. A summary of the mNGT results is available in Appendix 1.

The results are presented according to key themes developed through the integration of the CCG (Kurtz *et al.* 2003), the core skills of clinical yarning (Lin *et al.* 2023) and abductive analysis of the data. Appendix 2 provides a tabulated comparison.

Themes are reported first according to the top five mNGT-identified priorities, followed by themes that highlight areas of both alignment and divergence with these frameworks, including points that reflect conflicting participant priorities. Each subheading reflects the overarching theme, accompanied by the original phrasing used during the mNGT exercise.

The top five mNGT-identified priorities

Demonstrate high-level clinical knowledge and skill/ knows how to diagnose and treat disease

Participants described a good GP as clinically competent: knowledgeable, accurate in diagnosis and management, holistic in care, and aware of their limitations. They valued clear explanations, education and shared decision-making. Although clinical skill was seen as most critical, being treated as a whole person not just a diagnosis, was also highly important. In the mNGT, clinical competence was ranked as top priority: 'I don't care if they are kind to me; if they diagnose my illness correctly' (Group 1). Participants valued GP knowledge of Closing the Gap initiatives (CTG; an Australian Government strategy aimed at improving health and life outcomes for Aboriginal and Torres Strait Islander peoples; George et al. 2025) initiatives, especially for accessing subsidised care, but emphasised that respectful attitudes and communication

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were just as important. Some preferred other staff to handle initiative-related roles and stressed the need for consent.

Participants stressed the importance of approaching health literacy sensitively, without highlighting the health disparities between Aboriginal and Torres Strait Islander peoples and non-Indigenous people, and ensuring concerns are addressed appropriately: 'Do you have to remind everyone that they're going to die younger? Aboriginal people already know that because it's shoved in their faces all the time'. (Site-B:P7)

Avoid medical jargon/explains using basic words

Participants identified communication challenges as stemming from medical jargon, lack of clarity and insufficient follow up. Clear communication supported patient understanding and engagement. Participants described challenges with language barriers, including foreign accents. Although some welcomed GPs learning traditional language, others found it offensive, mocking or reinforcing power imbalances. Most preferred clear English, and respectful use of language with permission. Rather than relying on aids, participants emphasised a conversational approach and plain language as key to effective communication.

Politely greet the patient/welcome the patient with a greeting; for example 'hello'

Participants strongly valued a warm GP greeting. Interviewees emphasised the impact of first impressions: 'It's how they [the GP] ... call your name if they got a smile ... their tone soft, subtle, inviting. I love eye contact, eye contact is a big thing'. (Site-A:P23)

The term 'respect', as used in the clinical yarn (Lin *et al.* 2023), proved complex, as participants identified a broad range of respectful behaviours, including kindness, care, pleasantness, honesty, courtesy, politeness, cultural awareness, sensitivity to power differentials, providing holistic care, being non-judgemental, showing deference to Elders, avoiding condescension or paternalism, not stereotyping, seeking consent, treating patients equally or like family, taking concerns seriously, promoting privacy and making appropriate eye contact.

Demonstrate appropriate outward behaviour/not stereotyping

Avoiding stereotypes aided patients to tell their story, with participants sharing how assumptions based on identity or skin-colour led to disengagement. Participants wanted to be seen as individuals, not reduced to labels, statistics, diagnoses or assumptions.

Consistently emphasised were the GP's attitude (respect, compassion, kindness, patience, honesty, cultural interest and non-judgement) and behaviour (voice tone, openness) as critical to feeling safe and respected. Participants also described a 'good' GP as being pleasant, personable, nice, positive, friendly, happy, smiling, casual, happy-go-lucky, fun, outgoing, engaging and willing to learn. Although the CCG includes 'demonstrates confidence', only two participants mentioned this, 'They don't need to be the most experienced person ... they have to come across like they know what they're doing ... But that they don't just always shout statistics at you' (Site-C:P2).

Politeness and respect ranked among the top 10 mNGT priorities, whereas the traits friendliness and humour ranked among the bottom 10. Participants recounted negative experiences with GPs who were rude, harsh, arrogant, disrespectful, condescending or dismissive, often leading to disengagement from care. Humour was noted as helpful for rapport among some, but others found it inappropriate, reflecting varied preferences.

Although non-judgemental care was a recurring theme, it did not rank in the mNGT's top 10, nor was it prioritised within the 'patient as a unique person' category: 'I don't like doctors that cock their nose up when you tell them the situation. I like doctors that understand' (Site-A:Joint interview 3). Preventative health care, particularly in relation to weight, was often mishandled or delivered in ways that felt dismissive, discriminatory or reductive. Participants also rejected attitudes that conveyed superiority or reinforced power imbalances. They valued being spoken to as equals, rather than being talked down to.

> Just by speaking to you like a normal person, not because they're the doctor and you're the patient. You know like, 'I've gone to medical school for seven odd years: I'm superior ... I'm better than you ra da ra da ra' ... talk to them instead of speaking through them or speaking at them. (Site-D:P1)

Listen/listens carefully

Active listening to the patient's story, central to the diagnostic yarn and reflected in the CCG as 'listens attentively', was the most frequently discussed skill and identified by 32 participants as a key attribute of a 'good' doctor. Being listened to made participants feel heard, validated and respected – fostering trust, confidence, satisfaction and continuity of care. Listening without interruption, clarifying and prioritising listening before notetaking signalled genuine care.

Many participants shared negative experiences where they felt unheard, dismissed or misinterpreted – often perceived as discriminatory. Examples included mismatch illness perceptions, 'I have Indigenous heritage, so you must treat my ear infection with antibiotics' (Site-C:P7) or receiving inappropriate treatment advice.

In the mNGT category of essential characteristics of the GP, 'listens carefully' ranked second overall. Participants distinguished this from 'takes time to listen to patients' stories', acknowledging that trust and storytelling often develop over time.

The GP's use of a computer also impacted perceptions of attentiveness and connection. Some participants viewed

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typing as part of listening, whereas others found it disruptive. Clear signposting regarding the use of the computer during the consultation helped maintain trust.

Additional themes illustrating alignment and divergence with the CCG are presented in a similar sequence as the CCG framework to support comparative analysis.

Obtain consent (particularly for the attendance of others in the consultation)

Participants consistently stressed the need for control over who is involved in their care, highlighting privacy as a priority. Consent when involving family in consultations was critical: 'My consultation's my consultation . . . it's up to me to let anyone else know'. (Site-D:P1). Some saw family presence as helpful for emotional support or understanding the care being discussed. Only two participants described family involvement as a cultural norm. In the mNGT, 'involves family members with consent' was ranked lowest among culturally safe GP attributes. However, group discussions often overlooked the qualifier 'with consent', focusing instead on family involvement generally. Consent and clear communication were also valued during procedures and physical examinations.

Support the patient's comfort

Participants viewed comfort broadly, linking it to the overall practice environment and its role in fostering safety. It ranked ninth among the top 10 culturally safe consultation features in the mNGT. Key environmental factors included a comfortable waiting room, culturally relevant décor, ambient noise such as a television, children's play-space, friendly reception staff and visible Indigenous employment. Although Aboriginal and Torres Strait Islander staff were generally welcomed, some raised privacy and confidentiality concerns, particularly around being treated by, or disclosing sensitive information to, people they know personally within the community.

Several participants viewed confidentiality as the foundation of the therapeutic relationship. Small actions, such as closing the consulting room door, significantly increased comfort. In the mNGT, Group 2 ranked privacy as low priority, despite comments strongly supporting its importance. Similarly, Group 1 rated confidentiality lowest, but appeared to assume it would be respected in general practice.

Timely care, adequate consultation time and unhurried appointments helped participants feel relaxed, heard, taken seriously, and respected. This attribute ranked among the mNGT's top 10 priorities.

Adopt a casual or conversational approach, ask non-medical questions, such as 'How has your day been?'

Facilitating the patient's story, a core skill in diagnostic yarning and described in CCG as 'encourages patient to tell the story', was frequently described as a 'normal conversation'. Participants preferred non-medical opening questions, rather than clinical phrases, such as 'What can I fix?'. Although yarning or normal conversation was valued in the interviews, it did not rank in the mNGT's top 10, and scored an average of six out of 10 in communication skills.

Participants ranked 'recognising patient's concerns and priorities' among the top 10 mNGT attributes, with some wanting to guide the consultation themselves, and others frustrated when GPs dominated the agenda. Participants valued GPs being able to sensitively ask questions, 'Because sometimes you don't have the words to say and you get shame, you know?' (Site-D:P5).

Demonstrates attentiveness and genuine regard for the individual

Only the social yarn explicitly includes the skill of finding common ground. It is often taught to medical professionals that building rapport with Aboriginal and Torres Strait Islander patients can involve asking about connection to Country, family or Mob (GPMHSC 2025). However, views on GPs asking patients about Country or Mob were mixed in this study. Some found it neutral or useful for connection, whereas others experienced it as irrelevant, intrusive, invasive or distressing – particularly those with fair skin, who felt their identity was being questioned. Concerns were also raised about privacy breaches when GPs referenced known kin.

> It's got nothing to do with them if you're from here or where you from. Are you from Timbuktu? It's got nothing to do with them. (Site-A:Joint interview 1)

> You make me cry, sorry. I don't know my Mob . . . We weren't let know anything about our heritage . . . Some doctors really don't care because I'm a light skinned Aboriginal. It's like you're not a black fella . . . I prefer not [be asked about connection] because I can't answer it – I just don't know. I'm sorry, I told you I'd cry . . . A sense of belonging is the big thing. When you've not grown up with it, you don't have it, there's no sense of home . . . So for a long time, you feel like you're just floating, you're not part of a wider culture, you are not part of the Aboriginal culture, you're somewhere in between where nobody really cares. (Site-B:P6)

In the mNGT, asking about Country or Mob ranked among the least important attributes (average 9.7/10). Participants noted that understanding the person mattered more than asking culturally specific questions.

Sharing information about oneself, a feature of social yarning, helped build rapport, and shift the dynamic towards mutual respect and connection.

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Use welcoming body language including attention to style of dress

Welcoming body language, central to the social yarn approach, but not explicitly stated in the CCG, was seen as a key signal of a GP's attitude and openness, shaping the tone of the consultation. Non-verbal cues were described as instantly conveying judgement or discrimination: 'When you put up with racism all your life, you know it [racism] instantly. It's something that just screams at you . . . I knew: because he stiffened'. (Site-A:P31).

Formal clothing, especially on male GPs, was perceived to increase power imbalances: 'Anyone that's got a suit and dresses up – they're very conservative . . . they're usually a person that really doesn't understand the Indigenous issues that Aboriginals face . . . you don't feel as welcome'. (Site-A: P33). Although dress style ranked low in the mNGT, participants noted that being too casual could also be inappropriate.

Provide continuity of care

Clinical competence was closely linked to continuity of care. Participants avoided returning to GPs who seemed unsure, were dismissive or lacked thoroughness. Where patients did return to a GP, the resultant continuity built trust, deepened GP understanding of the patient and their family, and reduced the need to retell medical histories – something many found exhausting and distressing. Although ranked mid-level in the mNGT (6/10), Group 3 narratives suggest continuity may be undervalued, with participants also frustrated with repetition.

Referring to their past medical notes, to identify a relevant non-medical touchpoint or shared reference, was seen by some participants as a sign the GP had listened and was providing personalised care. However, one participant felt this practice increased the risk of being judged by the GP based on their recorded history and past behaviours. Participants valued GPs who followed up on previous visits, results and referrals.

Be responsive to the impact of cultural, social, political, historical, and community factors on health and wellbeing, and provide equitable care that responds to each person's individual needs

Participants had varied and often limited understandings of 'cultural safety' and 'culture', making assessment of culturally safe care challenging. Only one explicitly linked it to colonisation. Some saw culture as preferences for Aboriginal and Torres Strait Islander GPs at AMSs or same-gender GPs. However, opposite-gender care was generally accepted. Most participants equated culture with genetics, ethnicity, disease risks, tailored health prevention and access to health initiatives. A small group viewed cultural inclusion as demonstrating respect for them as an individual, and of their Aboriginal and Torres Strait Islander culture, but many prioritised clinical competence and equal treatment over cultural inquiry. 'He [the GP] doesn't have to ask me about my culture – if it comes up, I will inform him. It's not important that he knows – as long as he treats me the same way he treats a non-Indigenous person'. (Site-A:P33) In the mNGT, "respects and understands culture" did not rank in the top 10 and received mixed ratings, reflecting diverse views.

Similarly, most participants did not link their personal health to colonial history: 'He's only got to understand me' (Site-A:P32). Some participants highlighted the importance of understanding Aboriginal and Torres Strait Islander history to promote equity, recognise ongoing injustices, and provide context for health issues. Despite this, 'considers the impact of colonisation' ranked among the 10 least important attributes in the mNGT. Although participants did not view this as directly relevant to their own health care, some acknowledged its potential significance for Elders.

Opinions were split on whether GPs should directly ask patients to determine cultural safety. For some, this was respectful; for others, it felt inappropriate.

> Just straight up ask 'Is it culturally appropriate?'. And say that because straight away you're acknowledging and showing that you don't want to offend, or you don't want to be disrespectful. (Site-A:P33)

> And just don't rely on blackfellas to educate you. That is your responsibility to educate yourselves. (Site-A:Joint interview 2)

The most reported form of discrimination and racism experienced was the lack of recognition and respect for participants' Aboriginal and Torres Strait Islander identity – felt most acutely by fair skinned individuals, who often experienced invalidation. 'I have had people question my heritage, especially when it comes to CTG like "Are you really Indigenous?" "You don't deserve to be here, you're white"'. (Site-C:P8) However, one participant noted fair skin sometimes shielded them from overt racism, highlighting the complex relationship between identity and appearance. Participants were distressed by GPs making assumptions about their identity, emphasising the right to self-identify or not disclose at all.

In Group 1 mNGT, 16% chose not to identify as Aboriginal and Torres Strait Islander peoples when presenting to general practice, and 25% disliked the question, 'Are you of Aboriginal and Torres Strait Islander origin?'. Reasons for this dislike included fear of stereotyping, being dismissed or rejected, mistrust, loss of cultural connection, feelings of shame and a perceived lack of benefit in disclosure – 'The minute you mention that you're Aboriginal, it's: "Oh well, nothing we can do for you. See you later: out the door"' (Site-B:P6).

Spirituality was also polarising. Definitions varied widely (including limited or no understanding, Christianity, religion, dance, connection to the afterlife, diet, smoking ceremony,

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traditional healing, bush medicines, black magic and medicine man), and over one-third felt it had no place in GP care, although those for whom it mattered wanted their beliefs respected. Others referred to the overlap between mental health and spirituality. In the mNGT, spirituality ranked among the least important priorities.

Discussion

This study explored the GP attributes that contribute to a sense of comfort and safety in consultation settings from Aboriginal and Torres Strait Islander peoples' perspectives, highlighting the diversity of individual preferences, and the limitations of standardised or uniform approaches to both clinical practice and the assessment of consultation skills.

The study suggests the value of using a combined framework that draws on both the clinical yarning model and the CCG to better understand and improve communication between GPs and Aboriginal and Torres Strait Islander patients. Each model offers distinct yet complementary insights into the consultation process, and combining components of both models provides a more holistic and culturally responsive approach. Although the CCG provides a clear structure for medical interviews, it does not sufficiently foreground relationality, attitude or the potential impact of cultural, social, political, historical, and community factors on health and wellbeing. In contrast, clinical yarning was developed for Aboriginal and Torres Strait Islander patients, highlighting the importance of story, connection and trust within the consultation.

Our findings reinforce established evidence that clinical expertise, clear and respectful communication, active listening, rapport-building, and non-judgemental care are foundational to high-quality, patient-centred general practice consultations across diverse populations (Kurtz *et al.* 2003). However, our study challenges certain elements of the clinical yarning model, such as finding common ground, demonstrating knowledge of Aboriginal and Torres Strait Islander peoples' culture (Lin *et al.* 2023), and the use of silence, and aspects of commonly taught cultural safety training (Brumpton *et al.* 2022). For example, a recent GPMHSC (2025) resource recommends asking patients where they are from, and notes that extended silence is a valued norm. Yet this study suggests that attempts to find common ground by asking about connections to people or Country can, at worst, be traumatising for some patients, and may potentially compromise privacy and confidentiality. In addition, participants showed varied preferences for communication styles, generally favouring eye contact while being less comfortable with silence. As with all components of responsive and safe care, these consultation elements should be approached with sensitivity and contextual awareness.

Similarly, the routine practice of asking patients to identify their Aboriginality during general practice registration should be critically challenged. Barriers to identification described by mNGT participants echo community-level barriers reported by the Lowitja Institute in 2010 (Kelaher *et al.* 2010) when the question, 'Are you of Aboriginal or Torres Strait Islander origin?', became a quality standard in general practice (RACGP 2020). Although participants acknowledged the connection between identification and access to CTG initiatives, systemic racism and the complexity of Indigenous identity may deter patients from identifying, ultimately limiting access. A question intended to enhance health outcomes may, paradoxically, contribute to harm. Creating safe conditions for identification may involve removing the question from routine administrative processes, encouraging GPs to use a yarning approach that allows identity to emerge organically over time and enabling CTG registration to occur independently of general practice.

Overall, participants held a pragmatic view of GP care, prioritising immediate, respectful and individualised care over a GP's broader cultural awareness or historical understanding of colonisation's impact on Aboriginal and Torres Strait Islander peoples' health. We argue that instead of focusing on cultural awareness – typically defined as gaining knowledge about Aboriginal and Torres Strait Islander peoples' cultural practices (Kerrigan *et al.* 2020) – consultation models should encourage GPs to consider the broader influence of cultural, social, political, historical, and community factors on health and wellbeing. This approach can be applied across diverse populations, equipping GPs with the skills to communicate effectively with patients, particularly those further marginalised by characteristics.

We propose that the CCG is enhanced by embedding elements of the social yarn during the initiation of the session. Box 1 illustrates how the CCG could be enhanced by modified social yarning.

Limitations of study

This study was conducted within specific communities in Queensland, where English was the primary spoken language; therefore, the findings should be interpreted within this contextual setting and are not intended to be broadly generalisable across Australia or internationally. Aboriginal and Torres Strait Islander peoples represent diverse cultures, languages, and ways of knowing, being and doing; and experiences may differ across regions and communities. Nevertheless, when the findings were presented at national and international general practice, and Indigenous health forums, Indigenous delegates affirmed the credibility and resonance of the analysis.

As with all qualitative research, there is potential for researcher influence in data collection and interpretation, and participants' responses may have been shaped by the interview context. These risks were mitigated through reflexive practice, team-based analysis and ongoing guidance from the Community Reference Group.

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Box 1. Initiating the session – Enhanced Calgary–Cambridge model incorporating modified social yarning.

1. Politely greet the patient.
2. Obtain consent (particularly for the attendance of others in the consultation).
3. Demonstrate attentiveness and genuine regard for the individual.
4. Use welcoming body language including attention to style of dress.
5. Support the patient's comfort.
   - Maintain privacy and confidentiality.
   - Attend to the physical environment: ambient noise, play space for children, artwork.
   - Appropriate allocation of time for appointments.
6. Demonstrate appropriate outward behaviour.
   - Respectful.
   - Avoid stereotypes.
   - Be non-judgemental.
   - Be aware of power differential and how this may be minimised.
   - Speak to the patient as an equal.
7. Be responsive to the impact of cultural, social, political, historical, and community factors on health and wellbeing, and provide equitable care that responds to each person's individual needs. Allow enquiry about personal identity to emerge over time.
8. Adopt a casual or conversational approach, ask non-medical questions, such as 'How has your day been?' or a touchpoint from previous non-medical conversations.
9. Listen.
10. Signal any periods of silence.
11. Recognise and respond to verbal and non-verbal cues, remaining sensitive to individual and shifting patient preferences (e.g. variations in comfort with eye contact).
12. Avoid medical jargon.

    As well as the above, GPs should be able to:
13. Demonstrate high-level clinical knowledge and skill.
14. Provide continuity of care.

Conclusion

Enhancing the CCG through the incorporation of modified social yarning may provide a culturally grounded communication framework for general practice, warranting further validation. Although the CCG provides a necessary foundation in structure and process, clinical yarning contributes the relational, attitudinal, and narrative depth required to align care with the priorities and lived experiences of Aboriginal and Torres Strait Islander patients. Furthermore, it offers a potential foundation for developing more culturally appropriate assessment tools that can evaluate both communication effectiveness and cultural safety of primary health providers from the perspective of Aboriginal and Torres Strait Islander peoples.

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Appendices

Appendix 1. mNGT results

In the mNGT, items were ranked on a scale from 1 (most important) to 10 (least important; Tables A1, A2 and A3).

Table A1. Top 10 attributes across three mNGT groups (1 = most important to 10 = least important).

Top 10 most important attributes, in order of decreasing importance	Group 1 ($n = 7$)	Group 2 ($n = 5$)	Group 3 ($n = 6$)
1. Knows how to diagnose and treat disease	1	1	1
2. Explains using basic words	1	1	2
3. Welcomes the patient with a greeting e.g. 'Hello'	3	2	1
4. Not stereotyping ('All Aboriginal people are the same')	1	2	6
5. Listens carefully	3	2	5
6. Recognises patient concerns and priorities	4	1	5
7. Doesn't interrupt	6	2	3
8. Polite and respectful	2	6	3
9. Creates a welcoming environment	1	6	4
10. Provides enough time for the appointment	3	3	5

Table A2. Bottom 10 attributes across three mNGT groups.

Bottom 10 attributes, in order of decreasing importance	Group 1 ($n = 7$)	Group 2 ($n = 5$)	Group 3 ($n = 6$)
1. Considers impact of colonisation on a patient	6	8	8
2. Curious – wants to know about what's happening with patients	7	7	9
3. Helps patient access services	5	9	9
4. Positive, reassuring, friendly, sense of humour	9	8	8
5. Considers spirituality in a consultation	10	6	9
6. Works with others to achieve best care	7	8	10
7. Acts professionally yet casual in approach (not stiff)	6	10	10
8. Dressed casually	9	10	9
9. Gets to know the patient before asking about connection to country/mob	10	9	10
10. Involves family members with consent	9	10	10
Bottom 10 attributes in order of increasing importance	**Group 1 ($n = 7$)**	**Group 2 ($n = 5$)**	**Group 3 ($n = 6$)**
1. Involves family members with consent	9	10	10
2. Gets to know the patient before asking about connection to country/mob	10	9	10
3. Dressed casually	9	10	9
4. Acts professionally yet casual in approach (not stiff)	6	10	10
5. Works with others to achieve best care	7	8	10
6. Considers spirituality in a consultation	10	6	9
7. Positive, reassuring, friendly, sense of humour	9	8	8
8. Helps patient access services	5	9	9
9. Curious – wants to know about what's happening with patients	7	7	9
10. Considers impact of colonisation on a patient	6	8	8

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Table A3. Ranking of all attributes across three mNGT groups (1 = most important to 10 = least important).

All attributes ranked from most to least important	Group 1 ($n = 7$)	Group 2 ($n = 5$)	Group 3 ($n = 6$)
Clinician–patient relationship			
1. Welcomes the patient with a greeting e.g. 'Hello'	3	2	1
2. Initial 'not medical' question e.g. 'How's your day?'	4	5	3
3. Shows they are there for the patient	5	3	5
4. Not condescending ('I am better than you')	1	6	6
5. Makes the patient comfortable	6	4	4
6. Prepares for the consult: reviews notes, remembers patient	8	1	9
7. Take time listen to people's stories	9	7	2
8. Not paternalistic ('I know best')	2	10	8
9. Show they are there for the patient	7	8	7
10. Gets to know the patient before asking about connection to country/mob	10	9	10
Communication skills			
1. Explains using basic words	1	1	2
2. Doesn't interrupt	6	2	3
3. Gentle voice tone	3	5	5
4. Not focused on their computer	10	3	1
5. Careful use of slang words	2	7	7
6. Sits and yarn/casual conversation	4	6	8
7. Relaxed body posture	5	4	10
8. Makes eye contact	8	9	4
9. Keeps silence to a minimum	7	8	6
10. Dressed casually	9	10	9
Essential characteristics of clinician			
1. Knows how to diagnose and treat disease	1	1	1
2. Listens carefully	3	2	5
3. Polite and respectful	2	6	3
4. Genuinely interested in helping	4	5	4
5. Confident when interacting with patients and staff	5	9	2
6. Knows about closing the gap initiatives e.g. CTG, 715s	8	4	7
7. Willing to learn about Aboriginal people	10	3	6
8. Curious – wants to know about what's happening with patients	7	7	9
9. Positive, reassuring, friendly, sense of humour	9	8	8
10. Acts professionally yet casual in approach (not stiff)	6	10	10
Patient as unique person			
1. Not stereotyping ('All Aboriginal people are the same')	1	2	6
2. Recognises patient concerns and priorities	4	1	5
3. Respects patient identity as an Indigenous person	5	3	4
4. Respects and understands culture	3	9	1
5. Not discriminatory	7	4	3
6. Not judgemental	8	5	2
7. Understands the patient's living situation	2	7	7
8. Considers impact of colonisation on a patient	6	8	8
9. Considers spirituality in a consultation	10	6	9
10. Involves family members with consent	9	10	10

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Table A3. (*Continued*).

All attributes ranked from most to least important	Group 1 ($n = 7$)	Group 2 ($n = 5$)	Group 3 ($n = 6$)
Optimising the GP environment			
1. Creates a welcoming environment	1	6	4
2. Provides enough time for the appointment	3	3	5
3. Ensures patient privacy	9	1	2
4. Follow ups on appointments e.g. treatment, results	2	4	8
5. Takes confidentiality seriously	10	2	3
6. Seeks patient permission or consent e.g. to include family, register for initiatives	8	7	1
7. Continues to care for the patient over time	6	5	7
8. Knows about available services and referral processes	4	10	6
9. Helps patient access services	5	9	9
10. Works with others to achieve best care	7	8	10

Appendix 2. Comparison of the Calgary–Cambridge guide and clinical yarning.

	Enhanced Calgary–Cambridge model incorporating modified social yarning	Calgary-Cambridge Guide (Bradford 2002)	Clinical yarning (Lin *et al.* 2023)
		Establishing initial rapport and building relationship	**Social yarn**
1.	Politely greet the patient	Greets patient and obtains patient's name Demonstrates respect	Respectfully introducing oneself to the patient
2.	Obtain consent (particularly for the attendance of others in consultation)	Introduces self, role and nature of interview; obtains consent if necessary	–
3.	Demonstrates attentiveness and genuine regard for the individual	Demonstrates interest	Finding common ground Sharing information about oneself
4.	Use welcoming body language including attention to style of dress	Demonstrates appropriate non-verbal behaviour - Eye contact, facial expression - Posture, position and movement - Vocal cues e.g. rate, volume, intonation	Welcoming body language Where appropriate, using humour
5.	Support the patient's comfort - Maintains privacy and confidentiality - Attend to the physical environment: ambient noise, play space for children, artwork - Appropriate allocation of time for appointments	Attends to patient's physical comfort	Attending to the patient's comfort
6.	Demonstrate appropriate outward behaviour	Accepts legitimacy of patient's views and feelings; is not judgemental	Validating the patient's perspective
	- Avoid stereotypes	Uses empathy to communicate understanding and appreciation of the patient's feelings or predicament, overtly acknowledges patient's views and feelings	Demonstrating empathy
	- Be non-judgemental - Be aware of power imbalance and how this may be minimised - Speak to as an equal	Demonstrate appropriate confidence	

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	Enhanced Calgary–Cambridge model incorporating modified social yarning	Calgary-Cambridge Guide (Bradford 2002)	Clinical yarning (Lin *et al.* 2023)
7.	Be responsive to the impact of cultural, social, political, historical and community factors on health and wellbeing, and provide equitable care that responds to each person's individual needs - Allows enquiry about personal identity to emerge over time	Provide support: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self care; offers partnership	Demonstrating awareness/ knowledge of Aboriginal culture
		Identifying the reason(s) for the consultation and gathering information	**Diagnostic yarn**
8.	Adopt a casual or conversational approach, asks non-medical questions, such as 'How has your day been?', or a touchpoint from previous non-medical conversations	Identifies the patient's problems or the issues that the patient wishes to address with appropriate opening question Encourages patient to tell the story of the problem(s) from when first started to the present in own words Uses open and closed questioning techniques, appropriately moving from open to closed Confirms list and screens for further problems. Negotiates agenda taking both patient's and physician's needs into account	Facilitating the patient's story e.g. through sensitive/responsive open-ended questioning
9.	Listen	Listens attentively: - To the patient's opening statement, without interrupting or directing patient's response. - Allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing If reads, writes notes or uses computer, does in a manner that does not interfere with dialogue or rapport	Active/deep listening to the patient's story
10.	Signal any periods of silence	Facilitates patient's responses verbally and non-verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation. Periodically summarises to verify own understanding of what the patient has said; invites patient to correct interpretation or provide further information. Clarifies patient's statements that are unclear or need amplification	Use of silence Summarising, prompting and clarifying
11.	Recognise and respond to verbal and non-verbal cues, remaining sensitive to individual and shifting patient preferences (e.g. variations in comfort with eye contact)	Picks up verbal and non-verbal cues (body language, speech, facial expression, affect); checks out and acknowledges as appropriate Deals sensitively with embarrassing and disturbing topics and physical pain, including when associated with physical examination	Recognising verbal and non-verbal patient cues
12.	Avoid medical jargon	Uses concise, easily understood questions and comments, avoids or adequately explains jargon Providing the correct amount and type of information Aiding recall and understanding	Explaining health information without medical jargon Using explanatory aids, such as stories, metaphors, visual aids and online resources Where appropriate, working effectively with Aboriginal cultural mediators, such as an interpreter

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	Enhanced Calgary–Cambridge model incorporating modified social yarning	Calgary-Cambridge Guide (Bradford 2002)	Clinical yarning (Lin *et al.* 2023)
13.	Demonstrate high-level clinical knowledge and skill	Shares thinking with patient to encourage patient's involvement (e.g. 'What I'm thinking now is...') Explains rationale for questions or parts of physical examination that could appear to be non-sequiturs During physical examination, explains process, asks permission Achieving a shared understanding: incorporating the patient's perspective	Understanding what the patient knows about their health issue Checking-in with what the patient understands and will take-away with them
14.	Provide continuity of care		

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