

Communicating medical information with Aboriginal patients: lessons learned from GPs and GP registrars in Aboriginal primary health care

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ABSTRACT

Background. Aboriginal culture stands as the oldest continuous culture in the world. It gives paramount importance to a harmonious balance between personal connections to the body, spirit, and mind, as well as collective relationships with family, land, and community, integral to the wellbeing of Aboriginal people. However, obstacles can emerge for patients due to language barriers, cultural differences, or a historical lack of trust in the healthcare system. The establishment of Aboriginal Community Controlled Health Organisations (ACCHOs) has undoubtedly improved the healthcare experience for Aboriginal patients, yet there is limited research on the specific approaches utilised by general practitioners (GPs) working in these clinics. **Methods.** Twelve semi-structured interviews were conducted with two groups of GPs working in Aboriginal health. Each GP was presented with three scenarios and asked questions related to each scenario. Braun and Clarke's method of thematic analysis was applied to transcribed interviews. **Results.** Patient-doctor relationship, health literacy, and engagement with the health system emerged as key factors influencing communication with Aboriginal patients. Experienced GPs, despite differing clinical backgrounds, shared concise yet similar ideas to their less experienced counterparts. Notably, experienced GPs prioritised non-medical conversations and mindful body language, emphasising the importance of building strong patient relationships over other consultation aspects. **Conclusions.** This research provides initial insights for GPs in Aboriginal health, comparing experienced GPs with more than 10 years experience to novices. However, further research involving Aboriginal patients is needed to validate GP strategies and understand their significance from the patients' perspective.

Keywords: Aboriginal community-controlled primary health care, Aboriginal culture, Aboriginal health, consultation skills, general practice, GP training, health literacy, Indigenous, patient-doctor relationship, patient engagement, primary health care.

Introduction

Australia, home to the oldest continuous culture, is one of the most culturally diverse countries in the world (AHRC 2014). Indigenous Australians place importance on balancing their individual connections with their body, spirit, and mind, alongside their collective relationships to family, land, and community (Gomersall *et al.* 2017).

Effective communication is crucial in a cross-cultural medical context, where cultural differences can significantly impact the patient-doctor relationship. Language barriers, cultural differences, or even historical distrust of the healthcare system can all pose challenges. To overcome these obstacles, healthcare providers need to adapt their communication style to suit the patient's language, literacy level, and cultural background (AMA 2022). In cross-cultural situations, healthcare providers must continuously develop their cultural competence by acquiring knowledge, skills, and attitudes, as well as examining their own cultural beliefs, attitudes, and assumptions (AIHW 2015; McKivett *et al.* 2019).

Aboriginal communities view time as circular, with the individual at the centre and important life events placed closer to them on the concentric 'time circles.' This contrasts with the linear western concept of past, present, and future. In Aboriginal culture, the

importance of an event determines its placement on the 'time circles,' rather than its chronological order (Janca and Bullen 2003). In Western culture, the linear concept of time emphasises the individual within the timeline. However, in Aboriginal culture, the focus is on the individual's context, which includes their family, history, and connection to the land, represented by the concentric circle of time. Therefore, it is important to understand this cultural difference and avoid misinterpreting it as lack of interest in personal health or disrespectful to the medical structure (Janca and Bullen 2003; McKivett *et al.* 2019).

Health literacy is elemental for effective communication and health outcomes. It refers to an individual's understanding of health information, and their capacity to navigate the health system and formulate their health-related decisions and actions (ACSQHC 2019). The World Health Organization (WHO) has identified health literacy as a priority cost-effective factor in achieving sustainable development goals in the battle against non-communicable diseases (Liu *et al.* 2020). Spoken languages correlate significantly with health literacy, with over 50 actively spoken Australian Indigenous languages with limited access to interpreters (Diversity of Language – Australia's Cultural Diversity 2021). Unfortunately, there are no national data describing the health literacy levels in Aboriginal and Torres Strait Islander people, but we know that 59% of non-indigenous Australian adults reported low levels of health literacy (Rheault *et al.* 2019). This indicates how complex it may be for even the general population to understand health information. Healthcare providers can use communication strategies to improve health literacy in Aboriginal health such as using plain language and visual aids, showing respect, adopting a holistic approach, and building trust. This may require extra effort and time from both patients and providers (Davy *et al.* 2016).

Aboriginal Community Controlled Health Organisations (ACCHOs) were established in Australia to address the health disparities experienced by Indigenous Australians. These community-led organisations provide culturally appropriate primary healthcare services that prioritise a holistic approach to health, community involvement, and the employment of a range of health professionals that can provide additional services beyond clinical care to address social determinants of health (Campbell *et al.* 2018). The rise of ACCHOs has significantly reduced the burden of chronic disease and increased the engagement with health services among Aboriginal and Torres Strait Islander people (Gomersall *et al.* 2017; Rheault *et al.* 2019). However, we recognised a gap in the literature about the experiences of GPs, and GP registrars training in those clinics, therefore we aim to address this gap in the present study.

Methods

This study adopted a qualitative model via semi-structured interviews. Given the nature and sensitivity of the topic and

our belief in the importance of collaboration and inclusiveness, an advisory group was formulated early in the process. This included representatives from the Aboriginal Health Council of South Australia (AHCSA), an Aboriginal health practitioner, an Aboriginal health medical educator, GPs experienced in Aboriginal health, and Aboriginal cultural mentors from the South Australian regional training organisation for general practice (GPEx). The role of the advisory group was to guide and steer the project as well as to provide expertise in a culturally safe environment. The Aboriginal cultural mentors were a male and a female elder from the community recruited by GPEx. Their roles included cultural education and support for registrars undertaking placements in Aboriginal health, as well as to help maintain a strong working relationship with the Aboriginal health training posts and the local Aboriginal communities.

The advisory group was formed in the early stages of the project and prior to the ethics application. The primary ethics application was made to AHCSA given that it is the peak body representing the ACCHOs in South Australia (AHCSA, n.d.). Approval was granted by AHCSA (AHREC protocol number: 04-21-929) and Flinders University (Project ID: 4629) ethics committees. The speed of the ethics approval has set a precedent, which was mainly a result of the inclusive mindset and the deep consultations (support letters from all stakeholders) made in preparation for this project following the famous motto 'nothing about us without us' (Charlton 1998). Meanwhile, given the limited scope of the study, which only involved GPs (not Aboriginal patients or an Aboriginal workforce), the recommendation from the AHCSA ethics committee was that, in order to develop resources and recommendations out of this study, there would need to be wider engagement and collaboration with the Aboriginal workforce. Therefore, we deliberately avoided producing any recommendations or resources as outcomes of this project.

Two cohorts were invited to participate in the research: experienced GPs (cohort A – seven participants) who had worked in Aboriginal health for more than 10 years; and GP registrars or new GP fellows (cohort B – five participants) who had completed a placement in Aboriginal health during their training.

Recruitment occurred via email invitations to experienced GPs listed on the AHCSA database; and to GP registrars, via GPEx, who undertook Aboriginal health placements between 2019 and 2021.

Interviews were conducted via Zoom and recorded as audio files only. They were based on pre-written scenarios of common Aboriginal health primary care presentations. Initially, five scenarios were formulated based on the most common causes of mortality for Aboriginal people as per the Australian Institute of Health and Welfare (AIHW 2023), which were subsequently reduced to three scenarios due to time restraints noted in the trial interviews. The three scenarios covered topics relating to polypharmacy in the context of chronic kidney disease and multiple other comorbidities;

cancer screening in the time of the COVID-19 pandemic; and grief in the context of family-related suicide (Supplementary material 1). All interviewees signed a consent form prior to the interviews and were informed of their rights to withdraw or abstain from participating at any stage of the project.

Experienced GPs were interviewed by the primary researcher, whereas the GP registrars were interviewed by a co-researcher who was a fellowed GP, to avoid any coercion with the primary researcher who was a registrar. All interviews started with a brief introduction about the participant followed by sharing the scenarios. All three scenarios had a similar format covering questions on: knowledge and thoughts prior to reviewing the patient, approaches and methods that would be considered during the consultation, and the use of physical or community resources.

Interviews ranged from 26 to 51 min. There were seven experienced GPs and five GP registrars/new fellows. Audio-recordings were sent to an independent external provider (Pacific Transcription) for transcription and checked by the primary researcher. The co-researcher was offered AUD90 per hour for their time and participants were offered AUD125 gift cards after completion of the interviews as an honorarium for their time.

Transcripts were de-identified and uploaded to Nvivo (ver. 1.6). The data was systematically analysed using the inductive thematic analysis approach, following the Braun and Clarke method. This involved text analysis, categorising key words and ideas into themes, and generating a codebook (Supplementary material 2). As the analysis progressed, the codebook was updated and refined to improve accuracy (Braun and Clarke 2006). An inter-rater reliability check was conducted independently by another researcher to improve reliability and validity of the codes generated while eliminating individual biases and interpretations.

Ethics approval

Ethics approvals were granted primarily from the Aboriginal Health Council of South Australia (AHREC protocol number: 04-21-929).

A cross-institutional approval was later granted via Flinders University ethics committee (Project ID: 4629).

All participants and organisations mentioned in this project have given written and signed consent to participate and be mentioned in this project.

Results

It was noted that there were strong themes emerging from the codes, which covered patient–doctor relationship (107 references), health literacy (139 references), and the engagement with the health system (85 references) (Table 1). Furthermore, there was strong emphasis on the importance of Aboriginal Health workers (AHWs) in the communication and rapport process.

Patient–doctor relationship

The patient–doctor relationship was a key theme in the interviews. Both cohorts focused on the importance of understanding the patient’s concerns and agenda, and addressing these during the consultation to make the patient feel their voice was heard.

That would be my primary focus to make sure that we are addressing the reason why she’s presented before then moving on. (Novice GP2)

The approach was commonly wholistic, empathic, kind, and patient-centric, which was thought to be a bridge to addressing other issues seen by the clinicians as priorities, but always included mentioning the patient’s strengths and positives. Similarly, outcomes based on a two-way conversation in a shared decision-making process were commonly mentioned in all interviews. It may even have involved sharing something personal or connecting personally in the relationship:

Potentially talking about my baby would be a way of humanising the encounter. (Novice GP3)

Although building rapport and having a trust relationship were commonly highlighted in both cohorts, it was noted that experienced GPs naturally went into more detail. They advised creating a normal non-medical conversation with the patients, including a high level of curiosity to get to know the patients and build a relationship with them.

Often, they’ll have a football team on their keyring or a shirt and we’ll start with that or start with the weather or start with – I don’t know, something where I feel there can be – yeah, a non-medical conversation starter on a shared topic. (Experienced GP2)

Such curiosity and patience were particularly helpful in difficult situations.

One experienced GP described those conversations as a ‘therapeutic yarn’, used more in an Aboriginal health context than in mainstream general practice.

It was a slight mentality shift highlighted by one experienced GP to allow patients to own the consultation.

You do have to prioritise the patient’s wishes, and somehow you have to persuade the patient that the things that you wish to talk about, they introduced and that’s in fact their wishes. (Experienced GP2)

Body language was mentioned spontaneously by all experienced GPs but not at all by GP registrars. Experienced GPs were highly alert to posture, eye contact and body language, which started from the waiting area and continued throughout the consultation.

Table 1. Summary of comments by all interviewees.

Topic	Experienced GPs	Novice GPs
Aboriginal Health workers role	<ul style="list-style-type: none"> Screen patients and build rapport and trust Provide information and context Help follow up and support patients Provide culturally safe space You can't go wrong following their direction They maintain patient engagement 	<ul style="list-style-type: none"> Provide comprehensive screening Organise community groups to raise awareness Provide cultural support in hospital setting Help identify key issues prior to the consultation Provide a safe space for patients to open up Provide patient context
Engagement with the health system	<ul style="list-style-type: none"> Time is elastic with patients Address main concern and then focus on preventive health Empowering Aboriginal people to speak up as they may be too polite to speak up Invest in other elements of wellbeing other than health (i.e. work) Community support is challenging for transient patients Referral to culturally appropriate services Allowing time to divulge more Family illness may trigger engagement Allowing patients to see a few people in the clinic will give sense of community support 	<ul style="list-style-type: none"> Assess level of engagement Home situation impacts engagement Presence of cultural support if sent to hospital Address patient priorities Address family/work situation that impacts engagement Assess financial/housing/family/food situation Access to community services Feeling overwhelmed can limit engagement Arrange transport Inhouse support may be more accessible
Patient doctor relationship	<ul style="list-style-type: none"> Share a bit about myself Make a relationship first Therapeutic yarning May use entire consultation just to build rapport May use terms like 'uncle' if they want Curiosity in their background story Accept silence even if uncomfortable Listen rather than lecture Offer cup of tea Listen and talk less Gentle little suggestions and questions 	<ul style="list-style-type: none"> Meet patient agenda Shared decision making Assess relationship history Establish rapport first then address primary concern Assess risk sensitively Offer cup of tea and biscuit Share personal story to humanise the encounter Check patient's feelings Check if cultural needs were met Work on a personal relationship to build trust
Body language	<ul style="list-style-type: none"> Respond to physical cues If defensive then sit back, drop eyes and chair to be lower than the patient to avoid aggressive posture or professional posture Handshake seems to be important for blokes Avoid eye contact and being aware of tendency to be directly friendly Body language may instil confidence in patients and is a big part Body language is important and clinician needs to pick on clues 	No comments
Health literacy	<ul style="list-style-type: none"> Assess patient understanding as a start There are good handouts to use if they were easily accessible though Listen to vocabulary used Asses level of education and the understanding of the health system Ask permission before giving handouts It's hard to find plain language summaries but there is certainly some around Ask patient to look at their results on the computer to give them a 'visual' You need to make the numbers simple to the patient Education is part of the management 	<ul style="list-style-type: none"> Picture based handouts are the best Time spent with patient is more valuable than handouts Patients use social media to learn The unknown leads to non-engagement thus focus on health literacy Multiple layers of screening in clinic allowing better understanding of what the patient needs Using traffic light system to visualise the problem Avoid handouts overload Culturally appropriate handouts can be too simplistic and main stream ones too complex so a conversation works best Competing with social media to improve health literacy

An extended version is available in Supplementary material 3.

Once I've called the person's name and identified him I'm also cautious about making eye contact – not just with Aboriginal men, but with Aboriginal people in general. (Experienced GP4)

They also touched base on those difficult conversations when patients sometimes refuse to engage or become defensive.

When people are defensive and not talking, it doesn't matter which culture they're from, it means that they're listening through a filter ... If they're suspicious and if they're defensive then I think that comes out very, very early, in which case I tend to just prop myself back a bit, drop my eyes, make sure that I'm actually at a lower level than them, so I'm not physically

proximate and I'm actually not looking over them. (Experienced GP2)

This emphasis on body language was one of the significant differences between the two cohorts.

Health literacy

Health literacy was an essential aspect of the assessment for both cohorts. One experienced GP indicated that understanding the patient's health literacy level allows the clinician to talk with them at a 'comfortable' level.

You're not talking down to them, but you're feeling that you're both kind of on the same page with talking about stuff. (Experienced GP6)

The GPs acknowledged the importance of understanding the patient's language, illness comprehension, and preferences for engagement and education. They stressed the need for dialogue and not solely relying on patients to volunteer information or doctors to inform patients about their treatment plans.

What he understands the medications are supposed to do for him and whether he actually thinks they help. Whether he actually takes them or he just thinks that they're something that he keeps the doctor happy with. (Experienced GP1)

Both groups of GPs recognised the power of social media as a source of information but also the power of community groups in building better health literacy levels especially in remote communities.

She would be the perfect client to get into that women's group for keeping on top of preventative health and things like that. (Novice GP1)

Handouts were an important part of building knowledge and awareness for patients. Handouts should first be accepted and/or requested by patients, be rich in pictures that give visual understanding to patients, and be written in culturally appropriate language. Acceptable language that is neither too simplistic nor too complex should be combined with the artwork. Meanwhile it all goes back to the relationship with the practitioner.

My patients don't need an Aboriginal artwork on the border to understand the information. (Novice GP4)

People who are wanting more information or wanting to go home and think about it, then that's something I can always just print off and provide. Also having the opportunity just to take the time to personalise the questions that she wants answered may be enough as well. They may not need the handout at that point. (Novice GP2)

Engagement with the health system

Engagement with the health system was the third main emerging theme. Both cohorts highlighted the impact of external factors on the individual's health. This included finances, housing, employment, community connections, and the connection to land and culture.

I think social aspects, whilst my agenda might be slightly different, if we don't address the social aspects, that we, potentially, won't get the follow-up or the medication changes that we need. (Novice GP1)

She's transient. So even access to finances, or support, or safe housing is something that I'd want to be, yeah, keeping in mind, before then we can move to the next level. (Novice GP2)

Time was highlighted as a challenge for engagement. Therefore, opportunistic screening was common in all interviews. Meanwhile, time was important too for better engagement.

I find it more important to get these patients in again. The more time with the patients the more you end up divulging, exploring, and finding out to then help guide the treatment. (Novice GP1)

This matter was 'accepted' by interviewees especially in challenging consultations.

This would be a consultation I'd expect would take longer than the allocated 30 minutes, so I'd kind of be mentally aware of that and okay with that as well. (Novice GP3)

For the less challenging consultations, GPs suggested patients rebook for a well person's health check. Interviewees repeatedly highlighted the importance of not overwhelming the patients in order to attain better engagement.

So trying not to do too much, but engage her, but also do enough that you're not just a kind of empty consult room, she leaves feeling like something's a little bit more in control. (Novice GP4)

Finally, both cohorts emphasised the importance of AHWs in all three major themes (48 references) as a 'bridge' with the community. They can help clinicians articulate cultural sensitivities in a safe way and provide context and structure to a consultation.

An Aboriginal health worker does a comprehensive screen, and then that can also help direct what else you would like to do in the consult. (Novice GP1)

They can even spend more time with patients who need more care and can bridge gender sensitivities and support patients in their health journey.

Particularly as a female inviting an Aboriginal man into my room, probably before I called him, if we had a male Aboriginal health worker, I would have a little chat to them to see if they know this man and whether they would – if I asked him whether he would like them in the room with him. (Experienced GP4)

They can also close the health literacy gap and empower patients to improve their understanding so they can make better choices about their health. Finally, their role is essential in all aspects of patient care.

I know there's Aboriginal health workers in the clinic. I'll just work with them, I'll follow their direction. I can't go wrong. (Experienced GP5)

Discussion and conclusions

Aboriginal people are highly interested in their health and well-being (Canuto et al. 2019), but wellness may be defined differently to a conventional understanding of health. The WHO defines health and wellbeing as being physically, mentally, and socially well, not only disease-free (WHO 2023). These interviews revealed how GPs within Aboriginal health services think, connect, and implement therapeutic management plans within an Aboriginal health context.

Both cohorts discussed how a consultation in Aboriginal health is multifaceted and complex. Understanding the patient's context was an excellent starting point for clinicians who had multiple issues to cover, but then were usually guided by the work of the AHWs who do the initial introductory screening. The involvement of AHWs is not only for screening or follow-up purposes, but also to bring better structure to the consultation, overcome cultural barriers and gender sensitivities, and improve health literacy for patients and their families on the short and long term. Aboriginal patients may experience barriers that are not as prevalent in non-Aboriginal contexts. These barriers could include feelings of shame, guilt, fear, and mistrust, as well as issues with judgment, misunderstandings, past trauma, and changing priorities. Some of the key communication skills highlighted by both cohorts include active listening, understanding patients' context, allowing patients to lead during the consult, non-verbal communication, and approaching patients using a relaxed demeanour (Table 1). While both cohorts valued the importance of building rapport, experienced GPs emphasised body language as part of this process.

A strong patient–doctor relationship is the cornerstone for any forward steps during a consultation in Aboriginal health. Aboriginal people come from a multitude of backgrounds, languages, and bio-psycho-social constructs, and therefore it is essential to listen to the context, address the concerns,

work harder on building trust, find common ground, establish priorities, provide clear information, and involve the right teams for follow-up. This is described in Aboriginal health as 'therapeutic yarning' which is a culturally sensitive approach to communication and relationship building that involves storytelling and listening with empathy and respect, creating a safe and supportive space for people to share their experiences and feelings (Bessarab and Ng'andu 2010). It facilitates finding a medium/metaphor of shared understanding with the patient and using that as a common ground to explain diagnosis and the importance of complying with a treatment plan (Lin et al. 2016). Finally, while developing the codebook, it was observed that themes could be more easily discerned from interviews conducted with experienced general practitioners (GPs). Despite variations in clinical backgrounds and experience, the responses of experienced GPs were concise yet exhibited similar ideas to those of less experienced GPs.

This research has multiple limitations that may have impacted the results. Despite using similar interview questions, the two cohorts had different interviewers which may have affected the type and depth of information gathered. It was also difficult to ensure a head-to-head comparison of the findings given the interviews had a different flow of conversation between participants. Furthermore, data interpretation was done primarily by a GP registrar who might have unintentionally extracted richer content from the experienced GPs' interviews. This was addressed by having a senior supervisor in the project with extensive experience in research and Aboriginal health to review the findings and address this bias. Moreover, these findings are not intended as recommendations to change current practices, as we did not test the approaches discussed nor validate them with Aboriginal and Torres Strait Islander patients. However, a GP training placement in Aboriginal health has been shown to have taught registrars the complexity and challenges in this field, as well as having an impact on the way they think about working with Aboriginal people. It continues to remain unclear whether clinicians' concerns were of significant importance to patients, as they have not been tested or validated with them. Furthermore, it was unclear how the clinicians developed and consolidated their thoughts and approaches in those practices and whether it was purely from personal experiences or from feedback they had from Aboriginal patients and AHWs. Further research including collaboration and leadership by the Aboriginal community is required to determine the effectiveness of all strategies used in a clinical rather than theoretical context in order to validate the above findings.

Supplementary material

Supplementary material is available [online](#).

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Data availability. Due to privacy and confidentiality reasons, interviews will not be publicly available; meanwhile, the appropriate data has been shared in the body of the manuscript.

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